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ABSTRACT

This manual, designed for Head Start staff, parents, and others working with handicapped and/or nonhandicapped children, gives general background information on physical, emotional, and cognitive disabilities and offers practical suggestions for handling classroom problems related to these disabilities. Staff planning is discussed in relation to classroom space, staff and consulting resources, parent needs, and the number and types of handicapped children to include in a program. Medical information is given on some physical handicaps and health impairments such as chronic asthma, diabetes, and epilepsy, along with suggestions for managing them in the classroom. Procedures to follow when referring children to special services outside the classroom are suggested. The appendixes contain suggestions for classroom materials and activities, an annotated bibliography of books on child development, films, and service directories. (SDH)

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Responding to Individual Needs in Head Start:

a Head Start series on needs assessment

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Part I: Working with the individual child

DHEW Publication No. (OHD) 75-1075

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I. Introduction

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PHASE ONE

This manual is the first step in an effort to develop a needs assessment kit to provide Head Start staff, parents and others with simple easy-to-use techniques to identify the child's unique needs and capabilities and to respond in ways that enhance the child's development. The kit is designed for use with *all* Head Start children and their families. It stems from the Head Start Improvement Innovation effort to individualize services for each child. The overall kit is described briefly later in this introduction.

This particular manual focuses on the handicapped child defined as the child who may require special education. It represents an early attempt to give Head Start parents, teachers, and other staff simple answers to their questions concerning the mandate that Head Start significantly increase services to handicapped children. Despite the focus on the handicapped child, this manual should be useful in helping staff and parents work in an individual and appropriate way with all children.

Such questions have been raised as: How will I know how to cope? Will I have enough help to manage the class properly and at the same time give a handicapped child all the special attention he requires? Will an emotionally disturbed child disrupt my classroom? Will a handicapped child frighten the nonhandicapped children in the class? Will the others pick on or abuse a handicapped child?

These are valid concerns. But we should remember that handicapped children have always participated in the program, and in most instances Head Start teachers have been successful in adapting their programs to provide a meaningful experience for all children, both the handicapped and nonhandicapped. The difference is that now there are likely to be greater numbers of handicapped children in the classroom, more with physical disabilities and more with severe and multiple handicaps. This obviously makes classroom management more difficult. We hope that the information provided about the disabilities of the children will be helpful to you.

It is obviously impossible to anticipate every situation that might occur in dealing with handicapped children. We do hope, however, that the manual will stimulate your own thinking about the problems of handicapped children, encourage you to formulate your own views about coping, and help you to explore other potential sources for ideas and information for dealing with new problems as they may arise.

Many teachers of handicapped children have observed that once they come to feel at ease, and capable of meeting the special needs related to a particular condition, they view children with disabilities differently: it becomes apparent that the handicapped child's basic needs are the same, except in degree, as those of all children. Once this stage has been reached, many teachers realize that working with handicapped children largely involves modification and adaptation of the techniques that they use to deal with all children. These require knowledge of the handicapped child's condition, and a certain amount of trial and error.

Those who have had considerable experience observing or serving children with special needs in Head Start agree that a number of advantages and benefits to both handicapped and nonhandicapped children can be expected from integrating them in the classroom. For example:

1. The handicapped child has the opportunity, frequently for the first time, to play and learn with nonhandicapped children.

2. The nonhandicapped child has the opportunity to learn to accept, to cooperate with, and to understand handicapped children. Sometimes acceptance is preceded by anxiety or rejection. One of the teacher's tasks is to help the class to accept those who are different.

3. The handicapped child's self-image has an opportunity to improve. He can acquire a sense of belonging. He has a chance to become more competent, independent and self-reliant while becoming more sociable and cooperative.

4. Seeing the handicapped child in the classroom with normal children helps parents accept more realistically the impact of the child's disability. This in turn, enables them to help the child reach his maximum potential.

The legislative mandate defines the term "handicapped children" to mean "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special education and related services." Many of these categories have been retained in this manual, and will be found in the table of contents. However, some of the legislative definitions of handicapping conditions have been supplemented by practical working categories which we hope will be of use to

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readers. The table on page 3 coordinates the legislative definitions with the chapter numbers and categories we have used in the manual.

FUTURE PHASES

As has already been pointed out, this manual is the first step in an overall effort to develop a needs assessment kit.

The second part of the kit which will be field tested during FY 1975 will consist of three components: I. developmental screening instruments, II. classroom assessment instruments, and III. program planning materials. These are intended to help the staff form a profile of each child's ability and potential so that the program can be adapted to individual variations in development which are characteristic of all children.

I. Developmental Screening Instruments

The purpose of the screening instruments is to assess previously unidentified children whose entry into and adaptation to Head Start may require special attention and planning. The screening process should be helpful in identifying children with social or emotional problems and cognitive lags or lacks, as well as physical handicaps. It should also be helpful in identifying socially or cognitively gifted children. It is recommended that wherever possible, Head Start staff do the screening in preliminary parent interviews and child observations before the child enters the class. The results of the developmental screening can be used by staff, in conjunction with health screening information, to decide an appropriate program option for each child, to evaluate the best classroom assignment for a particular child, and to alert staff to those children who may require further evaluation. The screening instruments will use simple, reliable behavioral observations of the child, in conjunction with the parents' report of his everyday behavior and developmental history. The handicapping conditions discovered during the screening phase as requiring special services will require confirmation by professionals trained in assessing such disabilities in children. Head Start staff may also want further professional consultation for these children, as well as for children with milder conditions.

II. Classroom Assessment Instruments

The purpose of the classroom assessment instruments is to provide the staff with methods and guides for observing and recording children's behavior so that each child's strengths and weaknesses can be identified. This will provide a developmental profile for each child, which will in turn serve as a guide to planning and organizing activities, space and materials best suited to the child's developmental needs. The initial assessment of the child's development will also serve as a baseline against which to evaluate his progress over an extended period of time. It can also assist the staff in discussing with parents their child's developmental strengths and needs, and can alert the staff to problems which may require staff discussion, discussion with the family, or consultation with or referral to pediatricians, neurologists, psychologists, and hearing and speech specialists. In short, the developmental assessment instruments are intended to be part of an ongoing, dynamic process which recognizes the necessity for periodic re-evaluation and planning as children grow and develop.

III. Program Planning Materials

The purpose of the program planning materials is to provide the staff with suggested ways to individualize and adapt the curriculum and other aspects of the program experience to the developmental needs of particular children. It will include suggestions and examples of setting goals based on children's developmental profiles, and suggested activities designed to achieve these goals. The program planning materials will also contain suggestions for classroom activities which permit and encourage different responses from different children, and so enable the teacher to promote individualizing experiences in a group setting.

This manual was prepared by an interdisciplinary group at the Judge Baker Guidance Center, Boston, Mass.; representing the fields of clinical psychology, developmental psychology, early childhood education, special education, social work, child psychiatry, and pediatrics. The work was funded by the Department of Health, Education, and Welfare, Office of Human Development, Office of Child Development pursuant to grant #H-1920.

A Reader Evaluation Form will be found at the back of this manual as Appendix 3.

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TABLE 1

Legislative Definition of Handicap	Manual Chapter and Title	
Mentally Retarded Child	IV.B.	The Mentally Retarded Child
	VI.J.	Mental Retardation
Hard of Hearing and Deaf Child	III.B.	Speech and Language Disorders
	VI.H.	Hearing Impairment
Speech Impaired Child	III.B.	Speech and Language Disorders
	VI.D.	Cleft Palate
Visually Handicapped Child	III.C.	The Blind Child
	VI.I.	Vision Impairment
Seriously Emotionally Disturbed Child	V.A.	Inappropriate Body Habits and the Child's Concerns with His Own Body
	V.B.	The Aggressive Child
	V.C.	The Hyperactive Child
	V.D.	The Withdrawn Child
	V.E.	Separation and the Dependent-Fearful Child
	V.F.	The Child Whose Sense of Reality is Seriously Impaired
	V.G.	The Neglected Child
	V.H.	The Battered Child
Crippled Child	III.A.	The Child With Motor Difficulties
	VI.C.	Cerebral Palsy
Other Health Impaired Children	IV.A.	Variations in Cognitive Development
	VI.A.	Chronic Asthma
	VI.B.	Bleeding Disorders
	VI.E.	Cystic Fibrosis
	VI.F.	Diabetes
	VI.G.	Epilepsy
	VI.I.	Heart Disease
	VI.K.	Sickle-cell Anemia

Please note that the inclusion of a condition in this manual does not necessarily mean that it is to be counted in compliance with the 10% legislative mandate. Nor does the absence of a condition from this manual signify that it is not a valid handicap. Decisions about whether an individual child is handicapped under the congressional mandate are to be made by professionals using Office of Child Development guidelines.

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II. General Concerns About Children With Special Needs

Head Start has always recognized the importance of full and open cooperation between all members of the Head Start team. By working together, by sharing their concerns about individual children, as well as about the program as a whole, everyone benefits. The social service staff, teachers and parents are all members of the team.

Integrating handicapped children into the classroom requires careful planning. In this chapter you will find some suggestions for staff planning in relation to classroom space, staff and consulting resources, parent needs and the number and types of handicapped children to include in the program.

A. ACTIVITIES OF THE STAFF IN RELATION TO CHILDREN WITH SPECIAL NEEDS

The Head Start staff is undertaking some new responsibilities in serving handicapped children, and staff people may find their roles changing somewhat depending on who has experience that enables her (or him) to meet these needs. Some teachers have had previous experience with children with some types of handicaps, but not with others. The social service staff and the community aides will also have some variations in their experience.

The staff of individual centers may decide to divide up the work a little differently to make use of experiences people have had or the types of problems about which they feel most comfortable in dealing with mothers or children.

One of the staff functions that is somewhat expanded now is recruitment of children and of volunteer assistants. Previously the primary criteria used when recruiting children for Head Start have been age, family income, and the ethnic composition of the community.

Now a new element has been introduced. At least ten per cent of all Head Start program participants must be children with special needs, i.e., handicapped children. Since it is unrealistic to expect every center to be able to meet the needs of *every* type of handicap, as recruitment proceeds each center should try consciously to assess the needs and resources of the center as a whole. In order to do this it will be necessary to know the percentage of children who are currently enrolled who do in fact have special needs, and how these special needs fit in with staff resources. Other important aspects of the center's resources are the training opportunities, the number of volunteers, the building in which the center is located, transportation, and agencies currently involved with the program.

HEAD START CENTER PERSONNEL

Since the inception of Project Head Start, staff has had ongoing in-service training. In the past, this training has centered primarily around the classroom activities and management techniques. More recently some of the training has focused on children with one or more handicaps. It is crucial that staff who recruit children not only know the content of the training, but also how other staff members felt once it was over. How helpful was it to them, and how comfortable do they now feel working with a child who has a specific handicap, e.g., mental retardation? This topic of staff acceptance can be included in a staff meeting agenda. Discussion of this and other needs can be continued in further sessions. At staff meetings there can also be pooling of staff information about schools, clinics, or agencies in your community that serve children with special needs. This information can be shared within the staff so that members working with particular problems can utilize these outside resources for the purpose of gaining additional knowledge for themselves and services for the children. Just as Head Start is to help children feel good about themselves, staff must also have similar good feelings, and confidence is the key. Special knowledge about the professional help available can make a substantial contribution to the building of that confidence.

VOLUNTEERS

From the beginning, Head Start has relied very much on volunteers to increase the adult resources, thereby providing more individualized attention for the youngsters. Now that there will be more children in the program who have special needs, the need for volunteers will undoubtedly be greater. The number of reliable volunteers presently working in the center, what their schedules are, and where they are assigned should be surveyed. It is important that you do not overestimate the number of additional volunteers you might be able to recruit in the future when considering the enrollment of children with special needs. Therefore, your survey should be accurate; do not rely on just guessing how many volunteers could be made available. Too many at any one time can lead to an overwhelming situation for the classroom staff; too few can leave the staff shorthanded.

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Since volunteers are not paid employees the staff needs to plan to use them during time that they can reasonably allocate from their other activities. A careful discussion with the volunteer about time allocation, explaining how important regularity is for working with children, may help in securing the commitment that is needed. Including the volunteers in the staff training sessions is likely to strengthen their sense of commitment. The knowledge the volunteer gains from training sessions can help her feel that there is some mutual benefit from her activities at Head Start.

Good sources for the recruitment of volunteers vary according to who is available in your community. Students in local high schools and colleges are frequently good resources particularly when they can be encouraged to learn from your program as well as giving help to you and the children.

PARENTS

Having parents participate in the Head Start program as volunteers is one of the ideal ways of bridging the gap between the center and the child's home. It is a very useful way of letting parents see for themselves how well their children are adjusting to the Head Start program, and what they are doing. Ask parents about things they might like to become involved in at the center. Many times parents have skills which the centers could use. When a mother has a special skill like playing the guitar, or making things appropriate for young children to do in arts and crafts, some planning about when she will come in, and preparing the children for her visit can result in a pleasant time for everybody.

Most mothers can help in the usual Head Start activities if they are given a little coaching by the staff. It is difficult for a mother to come in and help on a day one of the teachers is sick if she has had no previous experience in that classroom. Learning all at once where supplies are kept as well as the names and ways of different children hampers her ability to be a real help. Previous visits to the classroom on days when everyone is there can prepare her to help out in times of greater need. When the mother comes to class to assist the teacher, some indication from the teacher about the activity that she might work with or which children the teacher would like her to be with is helpful. Some mothers have an immediate capacity to see where help is needed and to pitch in, but a shy mother will tend to hold back unless the teacher has communicated some idea of what is planned and where the mother could best fit into the activity.

Parents should also be encouraged to participate in the training sessions set up for the regular teaching staff and volunteers. The more trained adults available to the center, the better. Parents are teachers too. They have been assisting in the development of their children from birth. It is important that the Head Start program should benefit from the contributions of parenting skills and knowledge and equally important that the Head Start experience should result also in a sharpening of those skills.

CONSULTANTS

The majority of consultants in the Head Start program are trained professionals who offer a vital service in the general fields of health, development, and education. The need for these consultants has increased along with the increased enrollment of children having special needs, and it may be helpful to enlist additional consultants whose specialties are more directly related to the handicapped children now coming into the program. These might include speech and physical therapists, teachers who are trained in working with children who have emotional or physical disabilities, and consultants from the staffs of agencies who are concerned with specific handicaps, e.g., National Association of the Deaf, National Association for Retarded Children, Easter Seal, to name only a few. The staff should make a point of knowing the service resources in the community, the purposes they serve, their fields of activity, and also their availability for consulting work.

When resource people come to the center, their visits should be arranged so that the specialist can observe the children and time can be scheduled for discussion so that classroom staff will have the opportunity to meet with the consultants for sharing mutual concerns, and alternative methods of working with these children. It will probably be necessary to arrange for volunteers and other staff members to assist in the classroom during the time that the teacher and/or teacher aide meet with the consultant. Arrangements should always be made in advance to ensure against leaving volunteers alone with the children. Staff are responsible for the supervision and safety of Head Start children and this responsibility cannot be shifted totally to volunteers.

The Head Start center personnel represent the number of adults who are available either as paid staff, volunteers, or consultants in the center on some regular basis to meet the needs of the program participants. Once you have assessed who they are, what they do, and when they are available to do it, then you can partly estimate the adult-to-child ratio and the types of resources that will be available to the classroom staff.

HEAD START BUILDING

The architecture of the building in which the Head Start center is located may in some instances help to determine

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the kinds of special needs that the center can or cannot adequately accommodate. Some centers are housed in the basements of churches, others are in large older houses, and some are in schools, just to mention a few of the various types of buildings. Wherever adequate space requiring little or no renovation has been made available in the community to Head Start, then that's where the center is located.

If classrooms are located in a basement or on the second floor, and a number of steps must be maneuvered, it might not be wise to recruit children whose legs and/or bodies are supported by braces or crutches, or who might even be in a wheelchair. Perhaps additional precautionary measures can be taken for the child's safety if there are only a few steps involved, i.e., installing a short ramp. Older houses also offer the possibility of 'adaptation' to a flexible integrated program. For example, a house with small rooms would be suitable for an "open" classroom arrangement, with designated rooms for various activities. It should be remembered that this requires staff planning and cooperation.

Most basements in buildings which are usually open to the public, like churches, have toilets, and also doors which open "out to grade." In these situations, the use of braces, crutches or wheelchairs should not present a problem in recruiting children who need these special supports. (Also see section on children with motor difficulties.)

OUTDOOR PLAY SPACE

Ideally, outdoor play areas should be adjacent to the center and enclosed. However, there are programs where the staff must walk the children a block or more to a playground every day. In these situations the hazards of traffic must be considered in relation to the recruitment of children with certain special needs.

During the interview with parents, or in the information that is received from a referring agency, a staff person may discover that a child has not yet developed inner controls with regard to his own personal safety; he may run into the street or may frequently hide from Mommy on shopping trips to the store. The steps necessary to ensure adequate supervision of the child on regular trips to the playground or occasional field trips should be discussed with the classroom staff prior to his first day at Head Start. There are ways of handling such a child, other than not enrolling him. Placing him in another class, at the beginning of the year, while his class goes on outings, and gradually including him is one possible way. Having more adults along on trips so that the teacher or teacher's aide can be responsible solely for this child is another way. Certainly there are other alternatives which might exist for children who have special needs which all of the staff can discuss. Remember, Head Start is a team effort and members of the team share many of the same concerns.

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TRANSPORTATION

Many Head Start programs provide bus transportation to and from the center. The bus driver on your staff should definitely be included in the discussions concerning recruitment of children with special needs. The number of adults accompanying the bus driver when transporting the child might need to be increased for closer supervision. The regular bus schedule and route should be reviewed and changed when necessary. More than one trip may be necessary. Additional safety devices, i.e. shoulder belts, could be priced and considered if there is the possibility of enrolling a child who has spastic cerebral palsy, for example.

THE SOCIAL SERVICE STAFF AND THE INTERVIEW

Once you have assessed the resources of your center, recruiting children with special needs which have been identified should not present as great a problem since you will be better able to assess with the parents the probable value of the program for their child. However, before making a home visit for the first time, there is information about the child which you should have received from the referring agency. Some things that would be helpful to know are listed below. Not all these things will be known ahead of time for every child, but when they are not, they should be dealt with early in the contact with the family.

1. Child's name, address, telephone number, and date of birth.
2. The names of the parents or guardians.
3. The names and ages of siblings.
4. The specific handicapping condition.
5. The medical history. If possible this should include the name of the clinic and/or doctor with whom the child has had contact.
6. The child's progress report, if possible.
7. Significant health factors of other members of the family.
8. Some indication of the parents' attitudes and general family acceptance or denial of the child's handicap.
9. A tentative plan for Head Start and the referring agency to coordinate their efforts with the family; this should include collaboration on the management and progress of the child.

The family interviewer will need to bring a "Request for Information" form which will be necessary in order to receive confidential information which the referring agency quite probably will not otherwise be able to release. This form must be signed by the child's parents or guardian and dated.

If the staff member who does the initial interview is well prepared for her visit both she and the mother will be more comfortable. Some of the information you need may be in the letter from a referring agency. Sometimes parents who have been dealing with a number of agencies must hear the same questions over and over. They may become irritated if they hear them again from you. Also your preparation for the interview will give some indication that you really do care about the child and his family, that you are sensitive to their feelings and concern, and that you mean to be of assistance to them, not a burden.

Of course there will be necessary questions you must ask, but try to limit them to getting information not otherwise available to you. Be sure to let the parents know that any information you receive will be treated in a confidential manner.

Some parents may have accepted the child's handicap, and the acute distress that often accompanies such a painful realization may be over. Other parents may still be having a hard time accepting the facts about their child's handicap. (See section on Parents of the Child With Special Needs.) Perhaps the referring agency has let you know where the parents stand in the process of acceptance of the child's problem. If so, you will have some information to guide you in your interview. If not, you will have to "feel" your way through it, relying on your sensitivity to tell you when to "back off" either by changing the subject or making an appointment to come back and finish the interview at another time.

Your observations of the parents and child during your interview will (1) assist you in possibly identifying some of the family's needs, and (2) enable you to report to other staff members the activities of the child while you were in the home. The latter observations will be of significant value in planning to meet the child's special needs.

It is important that you let the parents know the full scope of the Head Start program, including not only the preschool educational and social experience for the child but also the other services that could assist the total family. The participation of the parents through the Center Committee, Parent Council, and Policy Council should be discussed. It is important to bring parents into the processes by which decisions affecting their children are made. Head Start recognizes the fact that parents are the prime educators of their child, and the staff welcomes their assistance.

Make sure that you give yourself enough time for the recruitment interviews. Don't rush through them. By allowing parents to ask questions about the program you will create an atmosphere of equal exchange. Your recruitment interview not only sets the tone for the future success or failure of the parents' involvement and participation, but

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also opens the door for your future intervention, if intervention should become necessary.

CLASSROOM IDENTIFICATION

There are many instances where children having special needs are not identified until after they have been enrolled in Head Start. These will probably be children whose needs were not immediately visible during the recruitment interviews, or who have not been referred by an outside resource. Parents may give you a signal that careful observation of a child is warranted by describing the child as being slow, won't listen, lazy, or shy, etc. Such descriptions should be reported to the classroom staff when the child is being enrolled.

Teachers and teacher's aides will probably be the first members of the Head Start team to observe and discuss with the community worker a child who appears to have a special need. It may be necessary for her to get additional information from the parents about the child's developmental history and behavior pattern at home. It would also be good to find out whether or not anything different is happening at home which might possibly be contributing to the child's behavior.

Sometimes the information which is gathered and discussed with appropriate staff members may be cause to arrange a thorough examination of the child as soon as possible. Even if the center has signed parental consent forms for medical and dental examinations, it is always a good practice to keep parents informed about what is happening with their children and when. If it is at all possible, parents should be encouraged to accompany the child when keeping medical, dental or psychological (where appropriate) appointments. The staff may be able to assist in this effort by helping to arrange for a babysitter if there are younger children in the family, or transportation if it is necessary.

After all of the examinations and relevant testing has been completed and an actual diagnosis has been made that a child does have a special need, understanding of the family's possible reactions will be of significance in the staff's continued intervention.

In so far as is possible, a continued liaison with physicians or agencies who have referred handicapped children to Head Start is of considerable importance. This is also true about the professional resources that are providing services for those children with special needs who have been identified since they began to attend Head Start. The staff will need to decide by whom and how these contacts will be maintained. Though responsibility may be differently allocated for different children everyone needs to know who will take responsibility in each situation.

Collaborative planning and a ready access to help in times of physical or psychological crises can best be maintained by a plan that involves a periodic exchange of information between Head Start staff and other professionals who are helping the child. What may at first seem like extra work may in fortunate collaborative efforts be mutually stimulating and result in greater gains for the child.

B. THE TEACHER AND THE CHILD WITH SPECIAL NEEDS

Though many Head Start teachers already have some experience with handicapped children in their classrooms, the task of including more handicapped children, and perhaps some with unfamiliar difficulties, presents some special problems. For most people, knowing more about the difficulties they are trying to cope with makes the task somewhat easier. The teacher will want to find out about the particular needs of the handicapped children she is dealing with. She should also be well aware of the strengths and special abilities of the child in order to avoid treating him as *more* handicapped than he actually is. The goal here is for the teacher to develop reasonable expectations for the child which are neither too high nor too low.

The primary sources of information about children whose difficulties have been diagnosed prior to entrance to Head Start are usually the parents and the referring agency. The teacher may also want to supplement this information with more general information from reading about the handicaps she is dealing with in her class. Some references to sources providing information about handicaps are included in the bibliography in the final section of this manual.

Not all physical (or emotional) problems are equally handicapping for the child. Some, like asthma, involve periodic attacks of shortness of breath, but between attacks the child may seem perfectly normal. Others, like a clubbed foot or partial sightedness, may affect the physical appearance and behavior of the child at all times. Casts, braces, crutches, wheelchairs, special glasses, even a hearing apparatus are very visible and both the handicapped child and his nonhandicapped peers may react negatively to them. On the other hand, physical aids sometimes fascinate the nonhandicapped child; he may beg to try them out, even envy rather than fear the wearer.

An important factor in the handicapped child's reaction to his handicap is how others react to him. His early experiences in the home and in the neighborhood can affect his self-image either positively or negatively. And he brings

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this self-image into the classroom. The handicapped child with a positive self-image, can be a real asset to the group. Given normal support and protection against the usual classroom hazards, these children can do very well in Head Start. The child with a negative self-image, of course, needs more help. The management techniques outlined in other sections about children with emotional handicaps apply also to these children. In addition, however, the teacher needs to protect such children from the taunts of others. Often she can do this by example. If she is able to anticipate some of the needs of the handicapped child, for example, and clear the floor of objects which might trip the child on crutches, other children are likely to do so too. Simple statements such as "Let's move these books nearer to Johnny so that he can reach them," are likely to help the nonhandicapped child to feel that others are ready and willing to be helpful.

Assuming that the classroom has been arranged to facilitate the physically handicapped child's ability to move safely around the room ramps for children in wheelchairs, wall railings to help children who need such support, etc.—consideration should be given to the types of children who are to be included in a given teacher's group.

There are at least three major concerns in the selection of children for the classroom group:

1. Children who are physically handicapped and especially vulnerable should not be included in a classroom group with members who have extreme difficulty with the control of their aggressive impulses.

2. Several children with excessive needs for one-to-one attention should not be included in the same class.

3. Some account should be taken of the types of children the teacher has already successfully dealt with as well as the kinds of handicaps she may feel especially inadequate to handle.

Even within a reasonably well-balanced classroom, the presence of the handicapped children with special needs poses certain problems for the teacher and her aide. The teacher may find that she tends to focus most of her energy on children with special needs rather than on the majority of the class. This can happen because the child with special needs is a particular challenge, and the teacher wants to do well with him. By planning with her teacher aide and other available adults, the class as a whole can become the major focus of her attention. At times when she is engaged in some activity with the child with special needs, it is important that she has planned activities with her aide for the rest of the class.

Keeping all the children in the class engaged in meaningful activities can become difficult if too many children require prolonged one-to-one attention. Though the social service department and the educational director usually have some possibility of choosing in which class children may be placed, it may happen that a teacher will have a particularly difficult class. Since not all handicaps are diagnosed prior to the children's entrance to Head Start, a teacher and her assistant may in fact have a considerably higher proportion of children with special needs than was planned. Children with emotional problems may be particularly likely not to be recognized until their attempts to interact with other children in class make the difficulty obvious. Once it is clear that teachers have more children with needs for one-to-one attention than can be appropriately managed, some adjustments have to be made. Perhaps some additional adult assistance may be secured. The social service department may be able to recruit more volunteer assistance for her, or it may be necessary to plan reduced attendance schedules for some of the most difficult children. A teacher who is physically exhausted and emotionally drained at the end of each day cannot plan for the next day with enthusiasm and thoughtfulness.

When assessment techniques for all children are more generally used, more effective planning of the composition of class groups should result. If there is an effective match of children who can tolerate each other's difficulties and a core group of healthy children in each class, the teacher will have the opportunity to develop a class in which constructive socialization can occur among the children.

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C. PARENTS OF THE CHILD WITH SPECIAL NEEDS

Head Start staff members who worry over problems arising from classroom work with a handicapped child should bear in mind that the parents of that child have had the same worries over a much longer period of time, and probably in a more acute form.

Parental concern about a handicapped child begins on the day the parents first suspect that a severe chronic problem exists. The initial reaction often includes fear and anxiety, depression, guilt, even disbelief. This disbelief, which psychologists call *denial*, can be difficult to deal with, but is really a reaction that helps the family to survive a sudden very painful situation. The parents numbly reject the doctor's report: it cannot be true, they feel, that a child of theirs could be mentally retarded. It is not unusual for doctors to have to repeat such an explanation many times to parents who, understandably, cannot allow themselves to hear what is being said — the truth is too distressing. Usually this disbelief or denial will run its course, as the parents gradually accept the handicap and begin to learn how to deal with it. If denial does persist, however, it works against the best interests of the child because it diverts the parents from dealing with and planning for the child's real needs.

By the time you come in contact with them at Head Start, many parents will be well on their way to accepting the limitations and needs of their children. In fact, with children with previously diagnosed handicaps, a good deal of the information you need to know about the child you will get from the parents. Other children with problems may be identified only when the parents and teachers see the child in relation to other children in Head Start.

Now and then you may encounter a parent who is still minimizing the limitations a handicap imposes upon his child. This attitude may be transmitted to the child, who as a result may get into dangerous situations. For example, Karen, who has a hearing impairment, does not wear a hearing aid, and may not hear warnings to get out of the way. Or the parents of Amy, a mentally retarded girl, may say, "She may be behind other children her age, but she'll catch up."

Feelings of guilt are another problem to which parents of a handicapped child are prone. Parents may feel that they are somehow to blame for their child's problem. A mother may regard her son's cerebral palsy as a punishment of her for having had fleeting regrets in pregnancy that she was going to have a child. The father of a girl who can't get along with people may feel her antisocial attitude came from his having been depressed and irritable over the illness and death of his wife shortly after the girl was born.

Negative, resentful feelings toward the handicapped child are also common among parents. The child has cost the parents much anxiety, doubt, time, money and possibly embarrassment. It would be unusual for such parents not to have negative feelings toward their children. Usually the parents feel guilty about harboring negative feelings and don't express them. Often they won't even admit to themselves that such feelings exist.

In some families, these resentful, self-blaming feelings, in combination with the extra help that the child with special problems has needed, may lead the parents to give the child more help than he really needs. They may insist on overprotection for a number of reasons: (a) because they underestimate the child's abilities; (b) because they are afraid that a child who uses crutches, for example, may be hurt in a fall unless closely supervised; (c) because they feel guilty and try to compensate by giving the child as much as they can; (d) because they feel helpless and try to combat their frustration by constantly doing things for the child. Sometimes parents give up and neglect the child.

Seeing their handicapped child in the school setting can be a beneficial experience for parents. The sight of the child at play with other children may relax some of their exaggerated fears, and a realistic acceptance of the child's strengths as well as the child's weaknesses can be furthered by observation of what the teacher is able to expect and obtain from the child in the classroom. If, for example, the parents of Cathy, who has to use crutches to get around, have been overprotecting her they may be reassured by seeing her move around the classroom safely and playing with other children. Often, sending home what the child has done -drawings, paintings, or other constructions can serve as visible reassurance that the child can do things like other children.

Listening to parents can be of help to them. Many of the feelings about a handicapped child — embarrassment or shame over the child's appearance, sensitivity to the glances and reactions of others in public places — are feelings that most teachers and neighborhood workers might experience on field trips, and can understand. Parents will also have questions, some of which you will be able to answer and some of which you will not be able to answer. You should not expect to have all the answers. A particularly difficult kind of question relates to the child's future. A parent of a retarded child may ask, "Do you think she is going to finish high school and get married?" In this case, neither "yes" nor "no" will help, because we probably don't know at this stage of the child's development. The best answer is an honest "I don't know." At this point, the parent and the school need only make predictions about what is the next

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best step to take in order to promote the best development of the child's potential.

Parents can learn from other parents and can teach them as well. Some parents of handicapped children who previously have kept themselves isolated, may, through formal and informal discussion, share information, fears, hopes and plans with other parents. If the parents are unaware of the community and national organizations that exist to assist handicapped children and their families, they may learn about them from other parents. Head Start staff, too, can inform parents about these resources and help parents utilize these organizations to the best advantage. (See Chapter VII.)

It is worth repeating that you can learn a good deal about a handicapped child from parents. They are in a position to tell you what the child can and cannot do, and what his likes and dislikes are. You, of course, will have to evaluate this information in the light of your own observations of the child. Some specific matters on which the parents will have valuable information are:

1. The child's level of toilet mastery and his toilet vocabulary.
2. How to adjust any special aids the child has: hearing aids, braces, crutches, etc.
3. Any special requirements concerning food or rest.
4. What body skills the child has mastered, and where he may need help.

Other information often gathered from parents of normal children which is useful for nonhandicapped children, too, is:

5. The child's likes and dislikes in regard to activities and food.
6. How the parents teach him new things.
7. How the child tries to avoid things he dislikes doing.

While there are a number of positive contributions parents can and do make to the program, you can understand why talking to the teacher or the neighborhood worker about the child's problems may be painful to a parent. This is particularly true for parents of children with social or emotional problems. These parents are likely to feel even more guilty and conflicted about their child's problems than are parents of children with physical handicaps. Though the parent may inwardly blame himself, he is naturally defensive about how well other people think the child is being cared for. The parent may also be critical of how teachers and other children behave toward the child. A parent of a child in trouble may think the teacher should always see to it that the child's coat is still buttoned when the child arrives at home or that he never loses his mittens; that other children should always share nicely with him and never hit him or grab things from him, even though the children may be in fact retaliating for some of his aggressive behavior. The teacher can seldom secure this perfectly protected and cared for position for any child in her classroom, even if she thought it advisable. While it is useful and rewarding to be aware of some of the emotional problems confronting different parents of handicapped children, staff need not and should not be therapists.

If the staff can remember the extra burden of anxiety parents of handicapped children have to bear, it will be easier to tolerate some anxious criticism. In so far as she can, she will attempt to sort out reasonable complaints and try to remedy these difficulties. When she can, she will try to tell the mother how her child coped well with some ordinary problem of being in the group, and try to secure the mother's interest in her child's adaptive capacities.

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III. Management of Some Physical Problems in the Classroom

Perhaps you have never before considered the possibility that you, the teacher of a regular Head Start class, might have a student with a physical handicap in your classroom. The problems of dealing with a blind or deaf child, or a child with a physical disability may seem overwhelming. You may feel, to put it in mild terms, less than adequately prepared. Some of the teacher's concerns may be due to the unknown elements in the situation. You don't know exactly what the child will be like with you, how the other children will react, or what you will be like with the child. You probably underestimate enormously the help you can actually give the child. And you may be worried about whether you will do any harm. These are natural understandable concerns but the fact is that the child will probably benefit greatly from being in your classroom.

In this chapter there are discussions of children with problems of language or hearing, vision and motor difficulties. The emphasis in all three sections in on management techniques. Hopefully you will find suggestions here to make the entry of such a child into your classroom a smooth and positive experience. Remember as you read that the sections are discussing many different types of problems; they are not all going to appear in your room at once. Remember too, that you have an invaluable source of information in the parent, who has been managing the child's difficulties for as long as the problem has existed. And finally, remember that *what you have already learned about children in general is much more important than what you may still need to learn about the handicapping condition.*

A. THE CHILD WITH MOTOR DIFFICULTIES

Perhaps one or two of the children who apply to your Head Start program will have diseases of the bones, muscles, joints, or brain. In this manual we talk about cerebral palsy, muscular dystrophy and amputation, but we realize that those are only a few of the specific diseases and disabilities that can cause problems in locomotion.

The teacher's main worries about children with motor problems include the following:

1. What am I going to do about the mechanical equipment – braces, crutches or wheelchair – a disabled child may bring to the center?

2. Can standard outdoor or indoor climbing and gross motor equipment be adapted for use with the children who have disabilities?

3. How am I to know what these children can and cannot do?

4. How great is the danger of injury for a child who is unsteady on his feet?

5. What about the bathroom?

6. Will the child be able to keep up with the class or will I have to change my curriculum so that he can manage?

These questions pose real problems that call for answers, but they deal with what the child cannot do, rather than what he can do; how he might not fit into your program, rather than how he might.

Physically handicapped children often are denied not only the full uses of their bodies but also opportunities to explore their surroundings. By including the handicapped child in Head Start, you are offering him perhaps the only chance he might have to experience the normal pleasures of his age. Your classroom is rich with materials, language, action, socialization. It is a place offering the child a chance to discover through play who he is and what he can do, how to make friends and to understand how other people feel. We know that these discoveries are important for all children as part of growing, but especially for the child who is limited in his ability to get around.

The special equipment the child with a disability brings to the classroom should be in good working order. His parents can show you how to put on or take off braces, should that be necessary, or how to strap the child into a chair or standing table. Children in wheelchairs must have ramps where others have stairs, but these need not be permanent concrete. Temporary ramps are easily built. Floors should be checked for slipperiness. If floors are kept heavily waxed, rubber tips should be applied to the ends of crutches. The tips can be bought in any drugstore and are cheap. If the doorways have thresholds, remind the child to raise his crutches and lift his feet as he goes over. He may need to practice the maneuver a couple of times, but rarely will this be a problem.

You can adapt some of the regular classroom furniture to meet the special needs of children with disabilities. For instance, a child with spastic cerebral palsy may have trouble with balance when he is sitting. You can keep him safely on a chair by tying a wide, colored scarf around his waist and the back of the chair. A small block or juice-can

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can be nailed on the front edge of the seat of the chair to prevent a child's sliding off the edge of the chair. The technical name for such a device is an abduction block.

Children generally stand while engaging in certain table activities, finger painting, doll-washing, bubble blowing, brush painting, etc. Of course, a child who has trouble standing can sit, but you will need to raise the seating height enough to enable the child to reach comfortably. A wooden platform will do; so will four hollow blocks laid in a square and taped or nailed securely together.

In order to find out what the child can or cannot do, first ask the people who know the child best, his parents, his doctor, his physical therapist. They will be able to give you a general picture of what to expect in the way of physical performance: how well the child should be able to use outside equipment, how the child can walk, what his signals are for fatigue. Still, you are right in thinking that there inevitably will be many "on the spot" decisions for you to make. These are likely to be difficult at first, and most teachers tend to be cautious. Little by little, you will have to learn what his limitations are, and so will he. Then you can be ready to assist and he will be willing to ask for help.

A child unsteady on his feet may fall quite often when he is walking. These tumbles may be more frightening for you than for him. He is probably used to falling but perhaps should wear a helmet to protect his head. Many children who are unsteady have had training in the art of falling and know how to relax in order to prevent injury. It is not uncommon to hear one of these children yell "timber," as he goes down. But he has learned to relax when falling, and he scrambles for his crutches and gets back up. If such behavior worries the other children in the class, drag in an old mattress and let them practice falling too!

If toilet cubicles are large enough for wheel chairs and have hand rails, one problem is solved. If they are not large enough, someone must be available to help the child. When a child comes to Head Start in diapers, the mother should be asked to send a supply of extras and some plastic bags for taking the used diapers home. Be as matter-of-fact as possible about the business of changing a diapered child. You don't have to make a secret of it, but neither do you have to do it in the middle of the classroom.

Almost certainly some of the activities going on in your classroom or on the playground will be beyond the capabilities of children with disabilities. But to leave these activities out of the curriculum is not fair to the rest of the children, who may need a great deal of strenuous physical exercise. There will be times when you will have to say, "I know you'd like to do it, Sam, but it isn't safe." At these times be ready to share some of the child's sadness about his limitations and offer him a substitute activity. Perhaps there is another child who would like to join in the substitute play with Sam.

We all know that many of the most interesting nursery school play takes place or can take place on the floor. No need to change that. Just remember to put the handicapped child on the floor too, where all the fun is. Moving from one floor activity to another isn't difficult if a child has a flat four-wheeled cart. He can lie on the cart on his belly and push himself around wherever he wants to go. There are fancy vehicles manufactured just for this purpose, but many department stores sell cheap lightweight plastic go-carts which work just as well and can be used by all

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children as part of gross motor play. Some further suggestions appear in the section on Materials and Ideas.

B. SPEECH AND LANGUAGE DISORDERS

Most three year old children are able to form sentences that can be understood. However, some children in this age group for one reason or another have a very hard time talking. In fact, among the most common problems occurring during the preschool years are those involving speech (forming sounds into words) and language (the communication of ideas through speech). For example, a teacher may notice that one child frequently tries to talk to others, but his words can barely be understood; another child may hardly talk at all, using instead babyish pointing gestures, wide-eyed looks and pouting to let people know what he wants. Parents and teachers often expect that young children will outgrow babyish or unclear speech at least by the time they enter first grade. Sometimes this is the case, especially when a child takes part in a group situation such as Head Start which encourages and supports easy, friendly conversation. Under such circumstances many children *do* make considerable progress in speech and language.

But sometimes a child of Head Start age has an extreme problem in this area. Instead of outgrowing the difficulty as he gets older, it may even get worse. This is especially likely to occur if the speech problem is tied in with more generalized intellectual deficits, emotional problems, or both. These children usually require special remedial help outside the classroom, as well as the help of the classroom teacher. As in any developmental area, the problem is to figure out what kind of help will best fit the child's needs.

Think a minute about the different skills involved in learning to talk: first, the child has to be able not only to hear, but also he has to have people around him who talk to him and to each other. He has to put his own ideas into words, express out loud what he's thinking about. His tongue, lips and mouth all have to move in such a way as to make sounds into words; and he has to *want* to talk to someone else, to feel important enough, and confident enough to talk to other people. Thus, a number of skills are involved in the development of speech and language. These include the *physical* skills like hearing and the coordination of mouth movements, *cognitive* abilities (the putting of ideas into words), *emotional* strengths (self-confidence and social interest), as well as *learning opportunities.*

In planning how to help a child whose speech is impaired, you may need professional advice. But you can gather many clues simply by paying careful attention to what the child does, and does not do. Here are some examples:

During his first days at school, Steven rarely spoke in the classroom, and when he did, the sounds he made were not really like words. He tried to play with other children, but often seemed not to know what to do. The teacher had a hard time getting him to follow directions, even when she asked him directly by name to join a group activity or to put his puzzles away. She thought he was quite stubborn, but then she observed that when a fire engine siren outside attracted the attention of the other children, Steven didn't notice at all. This incident prompted the teacher to have Steven's hearing checked. The test revealed that Steven had a serious hearing deficit. After being fitted with a hearing aid, he responded well to the special techniques recommended by the speech therapist.

Steven's situation highlights the advantages of early testing for sensory defects *before* preschool starts.

It is clear that Steven had not learned to speak properly because of his long-term hearing problem. Short-term hearing problems can also make a child unresponsive to verbal and other types of auditory stimuli. For example, the teacher may notice that a child who has previously responded well, suddenly does not do so. Sometimes a bad cold or an ear infection temporarily blocks his hearing. If the hearing difficulty persists after the infection has cleared up, he may require further medical attention. In any case, even though the incidence of deafness is low in children under five (less than 1 per cent), it is always wise to have the child's hearing checked whenever you are concerned about his speech and language.

Here is an example of a different type of speech problem:

Johnny, like Steven, rarely spoke in the classroom. But unlike Steven, Johnny's hearing was not impaired. However, the teacher did notice several other things about his behavior. Even after two or three months in the Head Start program, he rarely wanted to join other children in play, and stayed very much by himself. When he did join others, it often looked as if he was playing in a much more babyish way than they were. In general, his social development *seemed slow. The psychological consultant was called in to help the teacher work with Johnny and his parents, focusing primarily on Johnny's inability to relate comfortably to other children. Slowly the babyish behavior was replaced by more age appropriate behavior and concomitantly, his speech and language also improved.*

Talking to others is a *social* behavior. When a child's speech or language is immature or delayed for social and

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emotional reasons, as in Johnny's case, it is very likely that he will have trouble in other ways in the classroom, too, especially in playing with other children. Whether he is markedly withdrawn, or particularly immature for his age, if his hearing is normal, yet his behavior does not show improvement, it is often helpful to discuss this with the child's parents, and where available, consider evaluation by a psychological consultant.

To be sure, not all children who have difficulty in speaking do not try to talk.

Sam, for example, was an outgoing, friendly youngster. He got along fairly well with others and was much liked by the teachers. He always seemed to have something to say, but *it was extremely hard to understand what he was saying. Sam would repeat willingly and the teacher could finally figure out what he meant. But when a new assistant came in, she found it impossible to get what Sam was saying. The only other thing the teacher noticed was that he seemed a little clumsier than most when he was painting or coloring. The teacher tried to get him to imitate her speech. But this did not help. He seemed willing to try but unable to do it. When the teacher referred Sam for a speech evaluation, it was decided that he should work with the speech therapist once a week. It turned out that Sam's speech problem was related to a more general* neurological defect *which interfered with clarity of articulation. With special help, Sam was able to make some progress.*

Sometimes speech articulation (the way sounds are made) is unclear, because of awkward movements of the tongue or lips. Professionals call these problems in pronouncing words *articulation defects*. It is not unusual for the preschool aged child to have trouble with the pronunciation of a few sounds, particularly "s," "z," "th," "l," "r," and "w." Minor problems may disappear with time. But in some instances, when so many words are mispronounced that the child is very hard to understand, referral to a speech therapist should be considered. By the way, if one of your children is having speech therapy, the therapist may suggest that you do some corrective work in class, and if so, when and how to do it. Of course, no teacher will want to do so much correcting that the child will be too embarrassed to talk.

Steven, like Johnny and Sam, provides us with only a few examples of the many different kinds of speech and language problems resulting from physical, social and/or neurological deficits. Sometimes a child has more than one deficit, for example both a hearing and an emotional problem. Sometimes his intellectual development is generally slow. In other words, in some cases, mental retardation may be responsible for the delayed speech development. On the other hand, sometimes the slow development in the use of the English language is related to situational factors in the family, as when very little, if any, English is spoken in the home. Perhaps the parents speak another language, or perhaps very little talking in general goes on at home. So while the examples given show only a very few of the possible types of speech and language problems, they do tell us that speech and language are only part of the total development and experience of a child. If there are problems in speech and language, there may well be problems in other areas as well. Observing whatever you can about the child in general helps you to figure out what is contributing to the specific speech or language problem that you noticed originally. Here are some questions to ask, then, whenever you are concerned about the way a child speaks in the classroom.

Observe carefully and try to spell out for yourself exactly what troubles you about this child's speech and language. Does he —

- ☐ keep silent much of the time, not answer?
- ☐ pronounce most of his words very unclearly?
- ☐ pronounce particular words very unclearly?
- ☐ talk, but frequently express ideas which seem strange to you?

Besides the way he speaks, are there other kinds of behavior which concern you?

- ☐ doesn't respond to sounds in general
- ☐ doesn't approach other children
- ☐ seems poorly coordinated in his physical movements
- ☐ shows immature, babyish behavior
- ☐ seems generally slow to learn

Have there been any changes over the past several weeks? Has he improved?

What is known about the home situation? Is any of this information relevant to the child's behavior?

These observations may then be discussed by the staff, as well as with the parents. Staff will then be in a better position to decide whether to recommend further special evaluations, such as hearing tests, speech evaluation and intellectual testing. Where available, these evaluations by professional consultants will help clarify the nature of the child's problem and the preferred method of treatment.

While special services are not yet readily available within all Head Start programs, it is important to realize that the Head Start experience in itself can be of tremendous value to the handicapped child. Through his everyday contacts with other children, both normal and handicapped, the

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handicapped child has a chance to learn many things, including how to relate constructively through play to age equals. This type of learning is essential for healthy social and emotional development.

Where special services *are* available, and a remedial program is advised, intervention of one sort or another can be undertaken early while the child is still in Head Start. Take, for example, Steven's situation. Steven's hearing loss was found to be severe. A hearing aid was recommended and he was also given some special help from the speech therapist. The possibility of sending him to a special school for the deaf, instead of Head Start, was considered and rejected since it was felt that in his case some exposure to normal children would be very beneficial. An alternative plan for children like Steven might be a combination of a special school for the deaf on a part time basis, say two mornings a week, and Head Start for the other days.

Whether or not one handicapped child is receiving special remedial help, there are many things the teacher can do to help him in the classroom. Here are some suggestions that will make her work easier with children who, like Steven, have a severe hearing problem:

☐ When he first comes to the classroom, either on a visit before the actual start of school, or on the first day, make sure he knows where the bathroom is, where his cubby or coat hook is, where the playground or door to the outside is. It is also wise to have him survey the room to get accustomed to the playthings in it. (This type of orientation to school is, of course, also helpful to the child with normal hearing.)

☐ Ask the mother to tell you what words the child knows, and what pitch and volume are the easiest for the child to hear. Try speaking in that manner yourself so that you become used to it.

☐ If the child is wearing a hearing aid, ask the mother to show you how to make sure the instrument is in good order and turned on. (If you notice a child's ears are sore, infected or bleeding, report at once to the mother and make sure the child is checked by a doctor or nurse. Never force a hearing aid into a child's ear.

☐ Since many hard-of-hearing children will have to learn to *lip read*, when communicating with him in the classroom:

☐ Make sure the child is looking at your lips. Sometimes it is helpful to tap him on the shoulder or gently turn his head so that he is watching your face.

☐ Speak clearly and directly to him.

☐ Stand near him and squat at his level when you talk.

☐ Stand close to the activity you are talking about. Speak in simple short sentences; for example, "Do you want to swing?" Show him what you are talking about to give him a visual clue.

☐ Talk about interesting things that are happening now.

☐ When telling or reading stories, place the child in the group where he can see your face.

☐ Pick stories that are short and illustrated with colorful pictures, or provide a flannel board with pieces of felt that he and the other children can manipulate to illustrate action.

☐ Use gestures occasionally, but don't try to perform a whole pantomime.

☐ Demonstrate various art activities or games, or have other children do it for you.

☐ At music time, stand where the hard-of-hearing child can see your face while you are singing.

☐ Use musical instruments and lots of rhythm activities so he can participate by feeling the vibrations.

☐ Encourage deaf children to dance. They can respond to the vibrations of the music and they enjoy singing games such as Ring Around the Rosy and Looby Loo.

☐ Prepare for a field trip by showing as many pictures as possible. The deaf child then will know what to watch for on the trip. (This also holds, of course, for the hearing child.)

For further discussion of deaf children see Chapter VI on medical information about hearing impairments.

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What about children like Johnny who speak infrequently or poorly because of social and emotional problems? In handling all speech problems it is important not to force a child to speak. Even though at the time it might seem like a good idea to say, "No cookie unless you ask for it," try to avoid this approach since what it does is to make it enormously risky to get the cookie. Under this threat, many children just won't ask. So it ends up by the child's being deprived of the cookie while he continues not to talk. If he does ask for the cookie, it's usually an uncomfortable request. A better approach to try is this: offer the cookie and say, "Here is a cookie, Jim. You can tell me when you want another one." And if he takes up the asking option, praise him. He may not take it up the first time, but with repeated encouragement and praise for doing so he may at least begin to try to talk.

When other children are responding to questions or playing guessing games, give the nontalking child a turn too. He may be slow in the uptake but usually he does want to participate, to be like the others, and will begin to try to speak. Talk to him often and conversationally through the day, just as you do with the other children. Let him know you like him and like what he does.

If you know that the child has recently experienced a troublesome event, it may help him to have you mention it, but don't dwell on it. Talk quietly with him about it. It may help him to have you say, for example, "I know you have been having a bad time. Would you like to tell me about it?" He may or may not say anything but he'll feel comfortable that you know and understand.

Some children will play out their fears using the housekeeping corner, blocks, the doll house, or puppets. Let him do this. It's nice if you can be there quietly watching. But don't actually play with him, unless he invites you to do so; and even if he does, let him direct what you are to do. In other words, let him tell you in his own way how he experienced the event and how he feels about it.

When speech development is slowed down because of neurological defects, as in Sam's case, it is particularly important that the child be seen by a professional member of the staff who can help work out an individualized program to meet the child's needs.

It is not uncommon to find children with normal intelligence who have speech and language problems. Moreover, many of these children have neither grave psychological difficulties nor impaired hearing. What has delayed their speech is their inability to understand or remember the *meaning* of words. Such children have a special language disability known as *receptive aphasia*. Such difficulties often puzzle teachers. However, try to imagine what it must be like. Picture yourself among people who are speaking a foreign language. There you are hearing well but not understanding what people are saying. Words are used so quickly around you that you never seem to hear the same word twice. Think how many times you have to hear a word and have it linked with a meaningful event before you understand it. To remember the sounds and to produce them in order to express yourself takes even longer.

Children suffering from such a language disability usually need specialized help, but even if such help is not available Head Start can help these children. You don't need special equipment, but you do need to give some thought to what this child can gain from the various classroom activities. In general, procedures which help the deaf child also help the child with a speech learning disability. Here are some additional suggestions:

- ☐ Speak slowly, in short simple sentences, to the child's eyes.
- ☐ Use mainly nouns and action verbs.
- ☐ Have the object or event which you are discussing close by.
- ☐ Occasionally have the child repeat a particular word after you.
- ☐ Use the same word several times during the day.
- ☐ Make or use pictures of objects or activities to show the child in referring to words. When you tell the class that music comes next, for example, show them a picture of a musical instrument or a group of children singing.
- ☐ Teach words in clusters or categories. Take, for example, the food category: silverware, dishes, cooking, market and restaurant can be taught as a cluster of related words; or the toy category: bike, swings, seesaws are outdoor toys, puzzles, blocks and paints are indoor toys.
- ☐ Have large paper dolls or do some body-tracing to teach him the parts of his body, names for appropriate clothing, etc. Mirrors are good for this too.
- ☐ At story time, have someone read simple stories or picture books to him, with a small group of children, taking time to let the children repeat some of the words.

A more common language learning disorder is called *nominal recall*. Nominal recall is the inability to remember the words one wants to use. We all occasionally experience this failing when we can't remember someone's name even though we remember his face. Children with this problem have mental images of objects, actions and wishes that they cannot put into words. As you can imagine, this is very frustrating for them. Many children substitute "um – what-doyoucallit" or "thingamajig – youknow" for the word they can't seem to find. Others consistently begin each

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sentence with a repetitious phrase like "Know what. . . ?" "Let's see," "Ah, the other day. . ." They do this in order to gain time to put their thoughts into words while trying to hold the listener's attention. It's like trying to juggle three oranges with two hands: (1) keep your thought in mind, (2) find the words, and (3) hold the attention of the audience. Many young children use a variety of techniques to hold the listener's attention. Only *extreme* forms of the inability to remember words would fit the nominal recall disability discussed here.

One of the nicest, most helpful things you can do is to let the child know you are listening and can wait for him to search. Of course, in a busy classroom there are times when you can't wait or other children can't wait. At these times you can quietly ask, "Is the word you are trying to think of _____?" In a worse pinch you might have to express the thought for him. The thing to keep in mind is to try not to provide the words for him *all* the time. The more often a child uses a word the faster he'll be able to use it the next time. The first few times of waiting for a child to complete a thought may make both you and the child uncomfortable, but bear with it. Once in a while you might even say, "I know it's hard for you to remember the words you want to say."

Another common speech problem is *stuttering*. Stuttering is characterized by interruption in the flow of speech. Sometimes it takes the form of an inability to articulate certain sounds, sometimes certain sounds are repeated over and over, and sometimes the speech is merely slow with only occasional hesitations. In any case, the stuttering is likely to be aggravated when the child is nervous or worried about something that is happening at school or at home. For some unknown reason stuttering is more common in boys than in girls. Many professionals feel that since this particular speech problem may disappear with time and growth, it is unwise to call attention to it.

Some children have physical problems that affect their speech. Cleft palate or brain damage may cause poor speech. You may have noticed that children with cerebral palsy or brain damage drool excessively, talk through their noses, have peculiar stops and starts when forming sentences, make unusual tongue and lip movements, as well as peculiar movements of other parts of the face. Many of the suggestions for helping deaf and speech-disabled children are also applicable here.

Most people find it easier to remember a new word if they have something familiar with which to link the new idea. That is, if you know the words "knife" and "fork" and have a mental image of a place setting, "spoon" comes easily. If you know "apple" and "banana" are fruits, and have eaten an orange, it may not be too difficult to remember "orange." One of the best teaching aids found in most classrooms is the game of Lotto. When using it, have the caller hold up the card and name the picture — "Who has the wheelbarrow?" Lotto games are inexpensive, often found in the dime store, or would be easy to make. Since children seem to like to play Lotto, the aphasic child will not feel that he is singled out.

Teachers can also make colorful charts of cut-out magazine pictures in categories. You might have one on food in the housekeeping corner, transportation vehicles near the blocks and cars, colors near the easels, children's photos or outdoor clothing near the door to the outside. If you are stuck for colored illustrations of familiar objects, don't overlook the Sears catalogue, trade stamps catalogues, school supplies advertisements, or the Sunday magazine section of your newspaper.

Some children's picture books have things categorized. Many children like to look through these books at odd moments.

OTHER CLASSROOM EXPERIENCES

As noted earlier, some children have language problems because of a marked lack of experience with the English language. Lack of learning experience may result from various home situations: the family may not use the English language at home; one parent may speak English, the other only Spanish or Navajo. In the latter case, the child will be learning two different languages, his home language and English. Such *bilingualism* is not considered to be a condition which handicaps a child. In fact, many people feel that when a child grows up knowing two different languages, he really has the advantage of an especially rich learning experience. Nevertheless, it it true that when this child reaches Head Start, he may need help from the

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teacher to learn more English words. Spending extra time with him naming objects and describing activities in simple words can be very useful to these children. Sometimes the teacher herself may speak the home language that the child speaks. Because this will certainly help make the child feel more accepted in the classroom, many people believe that teachers should use the home language when they can. There are different opinions about this, however. Sooner or later youngsters will need to be comfortable in the English language, in elementary school and with friends outside the immediate family and neighborhood. So, whether or not the teacher can speak Spanish or Navajo, she will still help the child in the long run by using and teaching him English words. (For suggestions on teaching English to bilingual children, see the Head Start Rainbow Series booklet on Speech, Language and Hearing Program, Number 13.) Naturally the child should never be made to feel that his home language is less important than English. One of the ways this feeling can be minimized is by telling other youngsters in the room, for example, what some of the home language words mean.

Bilingualism is not the only reason a child may have had limited experience hearing and speaking English. Sometimes serious illness in the family may require efforts to keep especially quiet. Perhaps one or both parents may be hard of hearing. Or the parents simply may not take very much time to talk with their children. The family style of communicating may depend more on actions than on words. The teacher's main job here is to provide language stimulation at a level which meets the child's own current language abilities. Once again, this calls for observations. Some children will benefit most if the teacher gives special attention to naming the objects and describing the activities with which the child is involved. When a child does not respond to the teacher's request, or to another child's suggestion, it may be that he doesn't understand the words. Taking the child to get the soap, and saying at the same time, "Now we're going to use the soap to wash our hands" relates words and action clearly. Another child may understand fairly easily what others want, but needs practice himself in using words. One way to help a child get this practice is to give him choices, "Do you want to use the blue paint or the red paint?" When he tells you his choice, he is getting some of the practice he needs. Later on he will need to have the teacher take time to help him express many of his wants and needs.

Interestingly enough, the speech development of twins tends to be slower than that of singletons. This is especially likely to be the case if the twins spend most of their time only with each other. Under these circumstances some twins tend to develop a "secret" language, secret in the sense that they understand each other, while other members of the household remain baffled. In the preschool situation, the secret language is likely to be given up as the twins begin to play more with the other children rather than only with each other.

While severe lack of language experience may not occur with great frequency, it is still true that every child can benefit from increasing his mastery of language. In fact, many people feel that one of the most crucial experiences Head Start can provide for all children is language experience. Words help children grow in numerous ways: in getting along with others, in mastering all sorts of new skills, in thinking and solving problems. This doesn't necessarily call for lots of new materials, sleepless nights thinking up special language games, or fancy commercial language training programs. It does call for giving some thought to the everyday problems of using language in a preschool classroom: trying to listen carefully to 15-18 youngsters, many of whom are hard to understand; and finding time to talk, not only to the group, but also individually with each child, even if he is slow to respond. It is easy to recognize that children benefit from having someone listen and talk to them. But with any good-sized group of three and four year olds, it is not always easy to see how this may be done.

There are many kinds of activities for a group which provide the children with language experience. Reading and telling stories, looking at pictures and talking about them, playing telephone games, Simon Says, are all going to encourage children to listen to words and use them. These are valuable activities which children enjoy. But *any* activity can be enriched for a child by the addition of words. Describing out loud to a child whatever he happens to be doing helps him to put his actions into words, both for himself and for others. "You're building two tall towers, Jimmy, aren't you?" "That lion goes next to the giraffe." "Now you're putting some more blue in your painting." There is no better way to teach words and relationships than to relate them to the child's own activity.

Getting in the habit of putting things into words is the first step, then, in providing a rich language experience in the classroom. You want the children to learn that important things get said, and it's to their advantage to listen. When a teacher makes a point of saying aloud that the assistant teacher has a cold and won't be in, children learn to expect words to explain things they need to know. When a teacher repeatedly encourages children to tell each other what they feel, what they want, they may slowly rely more on words, less on grabbing. The child may then come to feel that words have an importance for him.

What if a child is talking to you and you don't

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understand or know what to say? Sometimes this happens because a child speaks too softly; sometimes, as we have discussed, his articulation is unclear; sometimes the child comes out with an idea you just can't make sense of. Whatever the reason, it can be an awkward situation, especially if you're trying to avoid asking the child to repeat what he's said. But all too often, the child is then left with no verbal response at all. No response leaves the child feeling that his words don't "work"; and he isn't learning how to do a better job of making himself understood. It pays to bend down to try to hear the whispered or mumbled words. It pays to help the child say again what he is trying to express, simply so that he will feel that there is some advantage to talking, that people are interested in what he has to say. Young children need to learn how to make their ideas understandable to other people. They learn only very gradually that teacher may not automatically know that "Jimmy" is the name of the pet dog, and not of a baby brother. When a teacher tries to get the child's message straight, the child is learning both to express himself better, and that people are interested in what he has to say.

It is also often hard to know how to respond when children make clearly untrue statements. Suppose Timmy declares he was chopping down trees in his house, or was chased by a monster, or is really six years old and not three and a half. Out of politeness, some teachers may merely express a skeptical "Oh?" Out of concern with truthfulness, other teachers feel obligated to get the child to say it isn't really true. Sometimes it's easy to forget that a very young child may not be stating clearly in words the difference between wanting to do something and actually doing it. You can help with this problem by saying something like, "Perhaps you would like to chop trees down," or "Perhaps you're afraid of a monster chasing you." In stories, too, you can help a child distinguish between make-believe and real. Similarly, when a child uses words incorrectly, there may be times when you want to help him find the right word, so that you can understand him better. Whenever children are hard to understand, there is a fine line between asking them to repeat to show your interest, and *not* asking them to repeat in order to avoid embarrassing them. Naturally there is no rule to follow here, only your own observations of the child and guesses about the kind of support he needs. You won't want to correct his speech or grammar in a scolding, blaming way. You won't want to make him feel he can't say anything right so he'd better keep quiet. But you will want to show him you value his words enough to try to really understand him. You will want to show him you can help him express himself better.

Children learn about using words not only from their own talking and listening, but also when they hear adults speaking to each other. All too often children and teachers share the feeling that children aren't supposed to be paying attention when adults are talking to each other. This is a mistake, because they usually can't help but listen in. Instead, if it is appropriate, encourage children to listen in, but try to have the adults talk in ways that are appropriate for the child to imitate and that he can understand. Personal messages that you would hesitate to say aloud in front of all the children, should probably not be said at all in the classroom. Other messages should be told loud and clear for all to hear. Use language that children can understand, let children in on your discussion of what to do next, which materials to take out, whatever needs discussing.

Words are the way people keep in touch with each other and with what's going on around them. When we help young children to enjoy using words, we are helping them to become more in control of their everyday experiences.

C. THE BLIND CHILD

The conditions that combine to provide a good Head Start experience for the child with normal eyesight are of even greater significance in the blind child's school experience. Any difference is largely one of degree. The personal preparation and the classroom situation that are desirable for the sighted child may in the case of the blind child be crucial. He will not so easily tolerate obstacles that most sighted children can find ways to overcome.

The following list of topics summarizes the personal characteristics and the classroom conditions that will be found to be relevant to the outcome of the child's experience in Head Start:

1. The child's readiness for a school experience
2. The size of the class
3. The experience and sensitivity of the teacher
4. The availability of professionals for consultation on the child's special needs
5. The richness of the classroom program and play materials.

The relevance of these topics to the blind child's school experience is important enough to warrant detailed discussion.

READINESS FOR A SCHOOL EXPERIENCE

The blind child who is ready for school will exhibit the signs of healthy emotional development. He will be ready for separation from mother and home. He will be free of

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the gross manifestations of withdrawal and self-stimulating behavior.

A history of previous social experience with siblings or peers is important. Previous successful relationships with children are beneficial to the child's potential for adjustment in the classroom. Such a history suggests that the child can assert himself, at least to some degree, among his peers and thus will be able to hold his own in the classroom.

Good development in the use of language obviously will be an asset to the blind child entering Head Start in company with children of normal eyesight. He should have sufficient command of language to make known his wants and needs, to make contact with the other children and to express something of his own experiences. This is not to say, however, that a blind child with limited command of language is doomed to failure in the classroom. There have been many instances of blind children who have leaped ahead in language development in the classroom as a direct result of their need to communicate with the other children. Such progress can be aided if the teacher is available to keep the child from withdrawing and to encourage him to speak up for himself. At the same time the teacher will be careful to avoid overprotection of the blind child by speaking for him or by interpreting his meaning or wishes unnecessarily.

SIZE OF THE CLASS

About fifteen children has been found to be the optimal size for a class that includes a blind child. The blind child functions best in a small group (a teacher with three to five children) where he can get to know the other children well through voice, touch, activities and other clues available to him. An open classroom with thirty or more children, even if separated into small groups, would overwhelm the blind child with its background noise. He would be unable to screen out the noise to enable him to discriminate known individuals and sounds. The next best situation to a small class would be a classroom divided with semi-partitions. A large class then could be separated into small groups and the noise kept to a minimum by the partitions.

If the blind child can be in a small stable group for the major activities of the school day, he will be able to make comfortable relationships with a few peers at a time and to acquire the sense of autonomy while belonging that is so important to his development.

It follows that the ratio of teachers to children will be an important factor in the successful integration of a blind child in a class of sighted children. A ratio of one teacher to four children, with one blind child in the group, would be the most desirable one. The teacher would be able to keep the special needs of the blind child in mind while still having the time to encourage self-reliant interactions with the rest of the children.

The physical characteristics of the classroom need not differ from those deemed appropriate for any other Head Start classroom or for preschoolers' classrooms in general. Contrary to popular belief, an adequately functioning blind child can orient himself well in a variety of settings. All he needs is a little more time and guidance to assist in his exploration of the space.

THE TEACHER'S QUALIFICATIONS

For successful supervision of a blind child in the Head Start class the teacher must have a thorough understanding of the developmental status of the child. Initially she obtains this understanding through interviews with the parents and through consultation with appropriate specialists or other experienced teachers.

An understanding of the differences in the developmental sequences of blind and sighted children is essential if the teacher is to recognize the difficulties that will slow or halt some of the blind child's accomplishments. Again, consultation with the parents and professional specialists will be helpful for the teacher here, as will some time spent on available literature on the subject.

The teacher will have to learn to adapt to the blind child's needs and his individual behavior and here again consultation will be helpful. For example, she will find that she must provide verbal descriptions in place of the visual clues she would give a child with normal eyesight. ("Come here; I am by the piano.") Or she will learn to accompany a verbal order ("Turn around") with a light guiding touch, as well as to expand her descriptions of activities to include the sensations of touch and feel that accompany the activities.

USE OF PROFESSIONAL CONSULTANTS

The teacher of a class with a blind child in it will teach herself to be aware of the other children's reactions to the handicapped child too. Do they react by withdrawing from the blind child, by bullying or with fright? They, as well as the blind child, will need her understanding. The reactions of the parents to the blind child may be of significance here, and the teacher may want consultation with a psychiatrist or psychologist on this point.

The teacher probably will want to turn to professionals experienced in educating blind children for assistance in deciding on appropriate goals for the blind child's experience in the classroom. A reasonable goal perhaps would be to make the Head Start class primarily a successful

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socializing experience and a happy introduction to schooling, but Head Start also should be able to offer the child new and constructive stimulation of his cognitive, emotional and expressive capacities.

For the blind child Head Start may be a revealing experience regarding his difference from normal children. The revelation that everyone else can see though you cannot is a difficult one to absorb. A professional consultation should be available to assist the teacher if she is called upon to deal with this problem.

To take on the teaching of a blind child is not an easy assignment. Experience and the ability to feel comfortable in teaching young children will be basic prerequisites. The teacher should not be in the position of feeling overwhelmed by the care of a handicapped child on top of her other duties and responsibilities. Especially in the first few months, the blind child should be expected to need more support from the teacher, more stimulation, more backing in his efforts to become one of the group. If she is to give extra time and thought to a special child, the teacher requires the assurance that conditions exist for her to successfully manage her classroom.

THE CLASSROOM PROGRAM

If some thought is given to the special needs of the blind child in relation to the usual activities of the other children, many aspects of the regular classroom program can be made available to him. In some areas his development probably will not be on a par with the development of the others, and his play necessarily will be on a less mature level. Without vision, he cannot be expected to be self-starting in play as other children are. He must depend on the teacher for stimulation to investigate new toys and other classroom materials and to explore new directions. Peer relationships will develop less rapidly. Some adult assistance probably will be required if the blind child is to be successful in forming one-to-one relationships with others.

Enough experience with blind children has been accumulated to predict with reasonable expectation of accuracy how a blind child will respond to usual preschool activities, including the Head Start program. A brief review follows:

Music: The blind child should be easily integrated in the class, but instructions for rhythmic activities may need additional clarification and some tactile guidance.

Painting: The blind child will enjoy the kinesthetic pleasure of using brush and paint. Sand added to the paint will give a textured dry surface which he can explore and enjoy. Plastic materials with texture will be more rewarding than the smooth surface of ordinary paint.

Block play: The blind child's constructions necessarily will be much simpler. This activity may be only minimally rewarding since the visual pleasure of the final product will be lacking.

Dramatic or imitative play (doll corner, etc.): The blind child's capacity to engage in mutual dramatic play will probably not be as developed as that of his peers. Blind children are slower to develop the capacity to represent themselves in doll play. At the Head Start age, doll play will be new to the blind child, and he will be less flexible in its exercise. He may still be quite object-oriented and unable to take a role and to incorporate dolls in his presentation of the role. For example, he may become involved in playing with the iron, the telephone, with the moving about of pots and pans. By 4½ years, he may be able to create a fantasy of himself in another role (as Daddy or Mommy, say) but still not be able to integrate his role play with that of other children.

Play with miniatures has no meaning to the blind child until the age of 4 or 5 at the earliest, especially when very small objects such as doll house furniture, small toy cars, dolls, etc., are involved. Play corners with child-size furniture and equipment (dishes, doll beds, etc.) which allow the blind child to center himself in representational or dramatic, imitative play will provide the most appropriate settings for the development of imaginative play. Even so, the blind child takes much longer than a sighted child does to appreciate the human characteristics of dolls, and he may therefore regard dolls as mere objects rather than vehicles for the imaginative self-representation usually expected in the doll play of children his age.

Water and sand play: This should be pleasurable for the blind child.

Trips: Goals for the blind child's pleasure and learning on trips may be different from the usual ones. Some experiences cannot be absorbed easily without vision, but the experience of joining a group on a visit will be constructive, especially if an adult can provide some continuity through verbal description. Wherever possible, there should be opportunities to touch, smell, listen. Other children would benefit from this approach too. Some compensation for the blind child's inability to experience visually can be offered by allowing him to bring back tangible objects. Some advance preparation may be necessary: the blind child may need briefing on parking, steps, elevators, etc. Some sensitive teachers have been able to make trips richer by encouraging the blind child to make the group aware of his own heightened experience of sounds, smells, and touch.

Nature and science: Usually any activity involving nature or science will offer many features in which the blind child can participate and maintain interest.

Play materials: Well-chosen play materials for sighted

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children are often useful with blind children as well. Materials which appeal to several senses, not vision alone, are stimulating to all young children, but the teacher will have to guide the blind child in his discovery of materials new to him. Left on his own, he may have little means of discovering what is available or how to use it. Gross motor toys, such as tricycles, large trucks, and other large wheel toys, will be pleasurable as will outdoor equipment such as slides, swings, climbing gyms, and seesaws. With assistance, the child should be able to hold his own in outdoor activities.

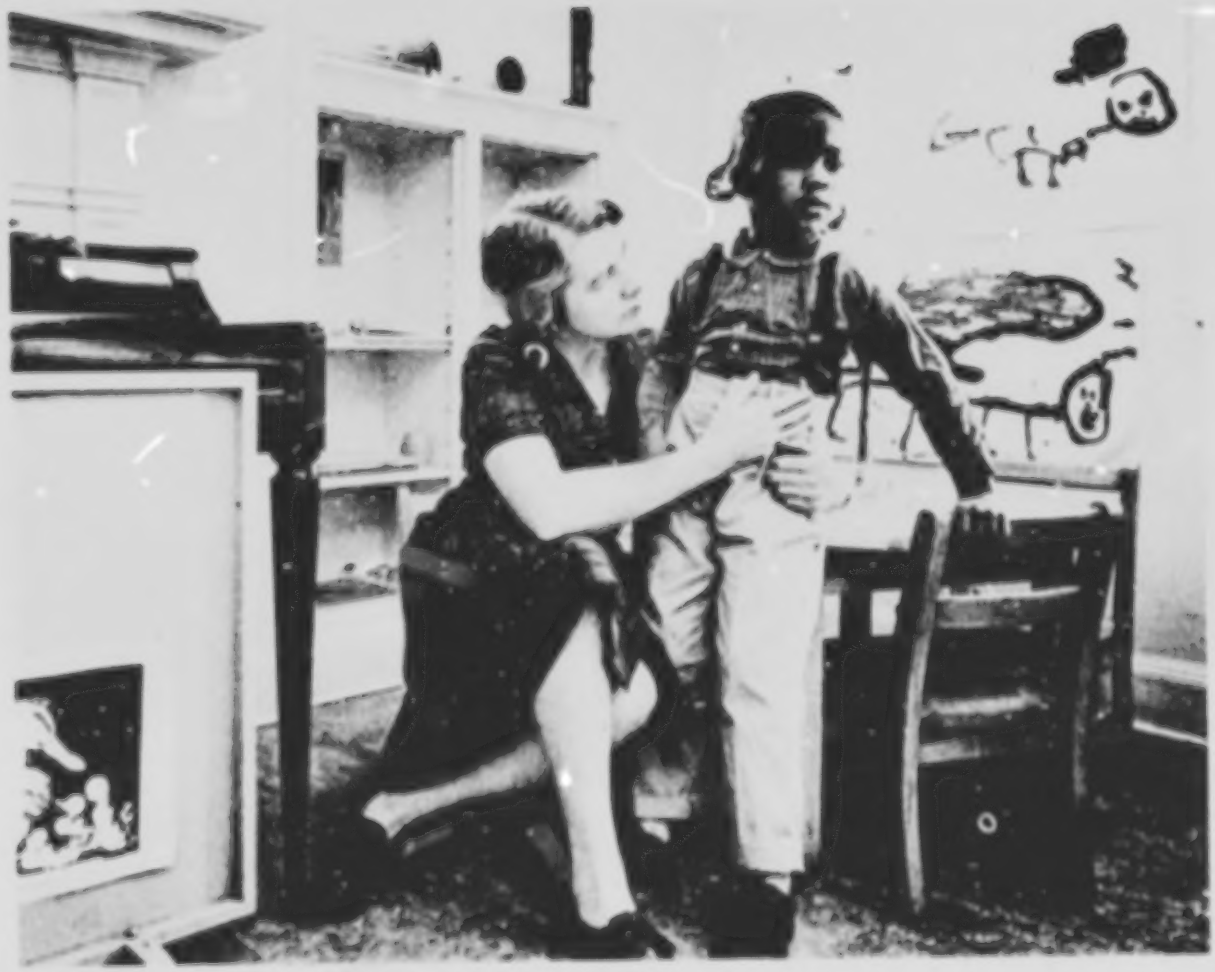
Story times and conversation times. Although many tales from our oral folk tradition can be enjoyed without benefit of pictures, many of the books read to young children are primarily picture books, hard to follow if one cannot see the pictures. Perhaps a balance can be struck between the two types of books.

"Show and tell" or conversation times can be shared quite fully by the blind child as long as he is given the opportunity to touch objects that are being shown and if the teacher remembers to cast descriptions in more than visual terms.

Eating. The blind child should be able to manage at meals if he is given clear indications of what is happening, what is expected and where things are.

Toileting. The blind child should be able to manage if he is shown where the facilities are and is told what will be expected of him.

In summary, the integration of a blind child into a sighted preschool program requires care, extra thought, sensitivity and some special knowledge. With these and with a clear picture of what the appropriate goals should be for a blind child's preschool experience, the adventure should be successful.



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IV. Management of Problems in Cognitive Development

Children differ widely in how they think and how they approach tasks involving problem solving and other so-called intellectual tasks. This chapter deals with how the teacher can observe individual differences in intellectual skills in children, and then plan her program to help each child develop the relevant skills.

A. VARIATIONS IN COGNITIVE DEVELOPMENT

Just as no two children have the same personality, no two children are alike in the way their minds develop. Particularly in the early years, children vary in what they do and how they learn, and it is important to understand that the range of this variation can be very wide. A child is by no means set for life with the abilities or learning potential he shows at three or four. Rather, he is constantly growing and changing, ready to be influenced by all the experiences that come his way. But every child develops at his own speed in his own special way. The skills he can learn best are the skills he is most ready for. So, recognizing and respecting each child's pace of development will help him to get the most out of his learning experience at Head Start. Naturally it is important for a teacher to understand what most three and four year olds can do. But it is also particularly helpful if she concerns herself with the special strengths and weaknesses she finds in each child.

The total intellectual development of a young child depends upon his progress in several areas involving different skills. These are: language and speech, perceptual abilities, fine and gross motor coordination, concentration and problem-solving ability. In thinking about the individual child's progress in any of these areas, you may find yourself continually wondering, "Is this typical or normal for his age?" Because young children vary so much in the way they develop these skills, it is extremely hard, even for experts, to answer that question. That is why many people have come to feel that other questions about children are more important. For instance, the teacher will find it useful to know (1) what the child's current behavior is in each area of development, (2) how his intellectual strengths and weaknesses fit into the total picture of what we know about him, and (3) what will help this particular child further his development.

LANGUAGE AND SPEECH: VARIATIONS IN DEVELOPMENT

Many of the variations in speech and language development are discussed elsewhere in this handbook. In Chapter III B are found descriptions of different language and speech problems, possible causes and suggestions for the teacher. Apart from these special problems, there is still much variation among most children in the way speech and language develop. A child's articulation may be perfectly clear; or he may have difficulty pronouncing certain letters, for example, "y" pronounced "l" or "l" pronounced "w." And, it may be hard to understand some children almost all the time. A child may often start conversations himself, or do so infrequently. In either case his speech may be babyish, for example, "Me want doll."

It is incorrect to conclude that the child who speaks less clearly or less frequently is not as smart as other children. The variations in development may be related to many different factors: differences in the rates of development of the nerves and muscles that control speech; in the rates of social development; and in the amounts the child has been spoken to or has heard others around him speaking. The important thing is to try and understand where a child can benefit from assistance.

There are certain observations a teacher can make that will help in supporting the development of children's language and speech. Some questions to keep in mind while observing are:

1. What exactly do you notice about the way the child speaks his words? Can you figure out when and why you have trouble understanding him?

2. Has his speech changed at all after he's heard others pronounce words correctly? Can he imitate words accurately? Try to determine whether the child speaks as he does simply because that's the way he's always heard people talk. It may be that he has special difficulty independent of what is going on around him. If he does have special difficulty, then it may be helpful to refer him to a speech therapist for evaluation.

Regarding a child's use of language, ask yourself what is significant about the way he communicates with those around him. To whom does he speak most? Teachers? Other children in school or playmates after school? Do you know anything about communication in the home? Does he listen with any interest to others? Does he seem to want to

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respond? Does he try to let you know his feelings by facial expressions or gestures? How does his communication fit in with his behavior in general? Does he seem generally withdrawn from others? Is his behavior noticeably babyish?

If you do hear him speak to other children, if you do observe that he is interested in communication, if the rest of his behavior does not seem particularly inappropriate, then the child may benefit greatly from being regularly spoken to in the classroom, without outside specialized help.

In the classroom there are numerous ways a teacher may foster language and speech development. All young children need to experience the advantages and pleasures of using words. There are many opportunities daily where you can show children the fun and usefulness of words: naming the play materials and activities for them, and having the children name them too; using snack time as a chance for friendly conversation – about everything from the type of cereal they're eating to someone's trip to a zoo. Storytime will be more fun if the children can participate by adding their own reactions or talking about the pictures. It's longer and noisier than having the children sit silently and listen, but they will be more actively involved in the pleasure of the story! Every time you put into words for the children what they are doing, what they are expressing to each other, or what they seem to be feeling, you are showing children the advantages of words. Whenever you take the time to listen to a child express himself, you are encouraging him to speak more often. Whenever two teachers speak to each other openly in front of the children, they are demonstrating how words help people share ideas and feelings.

Of course it may happen that the experience of being in the classroom does not sufficiently help certain children's language and speech difficulties. You may observe that a child continues to remain silent most of the time. First, it is always wise to have the hearing checked of any child who is slow to talk. But in addition he may also show very little interest in communicating with anyone in any way. He may also appear generally quite withdrawn or immature. Then it is advisable to seek outside assistance in evaluating the causes of the problem.

PERCEPTUAL DEVELOPMENT

Much of our thinking depends upon observing accurately what is around us. When we observe clearly enough, we can then move on to become aware of the similarities and differences among things. Children need to learn to distinguish shapes, colors, sizes and distance in order to understand that some things are alike and others are different. In this way, perceptual development plays a basic part in intellectual growth.

It is important to realize that perceptual development may vary from youngster to youngster. One child may not perceive very clearly that a triangle has three corners and a rectangle has four. If he can't see the difference himself, he certainly will not be able to tell you what each shape is called. For some children naming shapes may be a very simple task, for others nearly impossible. And any difficulty in recognizing shapes would also affect many other skills: doing puzzles, drawing or copying pictures and designs, recognizing letters and numbers.

Another kind of difficulty shows up when a child has to deal with groups or sets of things: several blocks, a picture of several flowers or balls or cookies. He may not be able to keep straight which is in front, which is behind, what's to the left and what's to the right. He cannot clearly perceive the order or positions of items in relation to each other. Thus, he may not always understand directions about what is behind or to his left or right. He may show great confusion about counting even small groups of things and may not be able to keep straight which items he has counted already and which items he hasn't.

If a child shows any difficulties of these kinds it does not necessarily mean that he is not very smart. However, it does mean that he hasn't yet reached the point where he can do the particular task. And it may mean that he needs special help. In the classroom when dealing with such a child it may help you to keep the following points in mind:

1. Difficulty on a particular task does not mean he is not trying or is not following directions.

2. You will find that it doesn't pay to push a child. Simply observe what you can about his difficulties.

3. Describe in some detail the problem he is trying to understand.

For example, you might point out that a square has four corners, and a triangle only three; or spell out exactly where he should look to find something, for example "in the block corner behind you," instead of merely "behind you."

4. His eyesight may be contributing to the difficulty. Have it checked.

5. If many perceptual difficulties are evident and there is little sign of improvement, the assistance of an outside agency may be required.

MOTOR COORDINATION

This refers to the child's ability to control his muscles effectively to carry out the activities he has in mind. Some of these activities, like drawing and using scissors, depend

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upon small muscles or what is called *fine motor coordination*. Other activities, like climbing and jumping, involve the large muscles, or *gross motor coordination*. Both fine and gross motor coordination improve increasingly as a child develops during the preschool years. But at the time children enter Head Start great variation is still evident. One child may be able to handle a pair of scissors comfortably, but can't keep his footing on the jungle gym. Another child may be good at climbing, but may not be ready to draw with crayons. These abilities usually develop in time, and the main job is to try to keep the child from becoming too upset if he has trouble with something he wants to do. It is wise to have on hand the materials that young children can use most comfortably. Thick crayons and felt-tipped pens instead of ordinary crayons and pencils; large paint brushes, instead of the little ones that are hard to control; large sheets of paper and easels; large building blocks of a sturdy material (the heavier blocks of wood are easier to balance than light weight blocks); puzzles with large pieces; left-handed scissors for left-handed children.

On the playground, it is all too easy to decide that some children are simply better climbers, jumpers and swingers than others, and leave it at that. The fact is a teacher can be helpful in important ways outside, just as in the classroom. A child who keeps stumbling may need active encouragement to try again. Another child may need to be told exactly where to put his feet in climbing down from a high bar on the jungle gym. Practice and time are required to develop all these skills, but they're just as important for the growing child's good feelings about himself as anything else he does at Head Start.

PROBLEM-SOLVING AND CONCENTRATION

Many people tend to think of problem-solving or reasoning as the most basic aspect of a child's intelligence. But in fact problem-solving is not a single ability that a child is born with. Rather, we use this general term for a group of skills that are helpful in many different situations. Problem-solving ability becomes apparent when a child is trying to judge where to place blocks to form a bridge; it is involved when he is deciding which pictures of fruit match in a Lotto game; or figuring out where to search for the lost piece of puzzle. Each of these situations demands the same skills. First, the child has to figure out what the problem is; then he thinks about or actually tries out different approaches to the problem. Above all, he has to keep at it. Despite uncertainty and mistakes, he must stick with the problem until he reaches a solution. Children differ in their approaches to a task and their ability to stick with it. These are skills that a teacher can help to develop.

By the time a child arrives at preschool, he has already had quite a history of successes and failures. He has begun to think of himself as particularly good or not so good at all kinds of activities. When he starts a new task, his approach is influenced by the amount of overall confidence he has achieved. Many children come to Head Start without having learned that they can solve some problems themselves. Either they don't try at all or they ask for help before they have even begun, or they simply move on to something else. They do not try to size up the difficulty of the problem because they have decided already that it's something they can't do. Adults often feel that all a child like this needs is a boost in confidence, or being told, "You can do it!" Sometimes encouragement works; much of the time it does not. What is needed in addition to encouragement is specific suggestions on how to go about trying. The bridge builder can be told to try out a block of a different size or shape. The Lotto player can be shown the different kinds of fruit pictures available. The child trying to fit in a puzzle piece can be told to try turning it around. If these suggestions

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bring the child to eventual success, he will know by himself that he can do it. And he will get extra pleasure from the teacher's enthusiasm over his success. Breaking down a task into separate steps often gives a child the guidance he needs to reach his goal. And, eventually he may be able to come up with these suggestions himself.

UNDERSTANDING THE VARIATIONS: THE ROLE OF INDIVIDUAL ASSESSMENT

There can be many different explanations of the variations children show in the development of their intellectual skills. Some have to do with the way the body develops its muscles and nerves. Others concern the feelings a child may be experiencing. The child's previous learning experiences are also a powerful influence. It is always very hard to know for sure *why* a child is having difficulty in a particular area. Sometimes you can make certain guesses, based on observations and information about what goes on outside of school. If you see signs of emotional problems – tenseness, withdrawal or other unusual behavior – you will be fairly safe in predicting that the problem will have an effect on the child's intellectual performance. If the child has come from a very deprived home, the limits of his experience may show up in the classroom. If a child's best efforts lead only to frustration, even though there is no history of emotional or environmental problems, you may wonder if there is neurological difficulty. And of course, more than one explanation may be true at the same time.

In the last few years, people have been thinking more and more about some of the difficulties described above, and in the section on hyperactivity, as *learning disabilities*. This is a term used to describe a special group of related difficulties which lower a child's performance when he begins standard school tasks in elementary school. From first grade on, the child with a learning disability shows unusual difficulty in learning to read, learning to write or to do arithmetic. His intelligence is usually at least as good as his classmates', sometimes better. But he *may* suffer from a special handicap in perceptual-motor coordination. Or sometimes, emotional problems interfere with the child's ability to learn. There are now special organizations in many states offering services to help children with learning disabilities.

Many professionals feel that it is not appropriate to designate a child as having a learning disability until he reaches elementary school age and then it becomes clear that he is not learning to read, or has severe problems with writing or arithmetic. In a preschool child it is simply too early to say whether weaknesses in perception and motor development are due to that child's particular rate of growth, or to a more lasting type of problem, persisting into the elementary school years. Many children who are having perceptual motor or language difficulties at the time of Head Start, will go on to do well in elementary school. You would not want to call a three or four year old child learning disabled when in fact you cannot know how he will develop in the next few years.

So, it is not possible to tell with reasonable certainty if a youngster will show learning problems when he begins elementary school. However, it is possible to see where that youngster's greatest needs lie now. Because learning difficulties *may* occur later on in some of the Head Start children you see now, it is all the more reason to pay attention to the areas where you can be of help. In one child you may observe that perceptual and motor skills need the greatest attention. In another child it may be certain feelings about doing things on his own that prevent him from ever finishing his drawings or buildings or games. In a third child, it may be limited language abilities (see Chapter III) that stand in his way. Whenever you move in to help a child with his particular needs, you may be providing the special type of assistance which will make the going a little easier for that child later on.

You will want to learn as much as you can about the child's strengths and weaknesses in order to know exactly where he needs help. Here is where testing comes in. Professional intellectual testing is a systematic way of having a child try out many different kinds of skills. When the test is completed, the examiner can see where the

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child's current strengths and weaknesses lie. This kind of information can be useful to the teacher, to compare and add to her own observations. The trouble with tests, however, is that they can be easily misunderstood. The teacher may feel that the examiner is getting a "true" picture of how smart the child will ever be. This is simply not so. An IQ will not give you a magical instant truth about the child or help to solve his problems, nor will any label about how far above or below average his intelligence is. The crucial thing is to understand and use the test findings to plan what can be done for the child. Thus, whenever possible, a teacher might want to discuss with the examiner what kinds of things the child did well and poorly on in the tests, and how she might best be of assistance. Because behavior on tests sometimes changes just the way classroom behavior does, it may be helpful after several months to have the child evaluated again to follow up on his development.

FOSTERING INTELLECTUAL DEVELOPMENT

Every Head Start program has its own special educational goals, and its own methods of working toward those goals. Within any particular program, however, questions may arise as to how to foster the intellectual development of individual children who show some of the variations we have discussed in this chapter. Making your own careful observations of a child's particular pattern of intellectual development is the first step in planning how to foster his growth. You are then in a position to decide in which areas the child needs most help. You can plan specifically how to help him, by encouraging the use of selected materials, or by spending time with him on certain tasks. And you may also become aware of those points at which he needs outside help. Observation and planning are basic, then, to any attempt at individualizing programs for intellectual growth.

But there is another fundamental aspect to intellectual development, one which is true of all children. Confidence in one's own abilities, as well as trust in the teacher, are an essential part of the process. Good feelings like these allow a child to become interested and involved not only in himself but also in what's around him. They allow a child to follow his natural curiosity, his natural desire to master new skills. Self-confidence helps a child recover quickly from discouragement and frustration. When something difficult comes along he will be more likely to try again and eventually succeed. And good feelings about himself and his teacher enable a child to recognize when he does need help and use assistance when he gets it.

Many children begin school with very uneasy, uncertain feelings about themselves. You may see it from the first day. Sometimes parents start the child off negatively by announcing to the teacher, "You're going to have your hands full with this one." Or perhaps the teacher has already heard what a trouble-maker a certain child can be. Deciding to see for herself, giving the child the benefit of the doubt, can help enormously. This attitude gives the child a chance for a fresh start. For if a child is to grow in the classroom, he needs to feel that the teacher has positive expectations for him, just the same as for any other child in the room. The teacher expresses this attitude by smiling and being friendly to all the children, but that's really only a beginning. Methods vary to fit the situation but the following general suggestions may be helpful:

1. Give a child praise for the things he can do well.

2. Respect the child's individual pace of development. Remember that in every area there will be much variation among your youngsters.

3. Whenever you step in to help a child, try to make your suggestions and demonstrations as simple and direct as possible.

4. Don't push a child to continue something obviously beyond his current abilities. Instead substitute something he can manage.

5. Allow children the excitement of exploring materials in their own way, even where it's different from the "right way" of doing something.

Naturally we want the children to get as much as they can out of the experience of being in Head Start. There are many ways to promote learning, and your Head Start class depends upon you and your staff's ideas about materials, methods and goals. Paying attention to the pattern of skill variation within each child will aid in reaching those goals.

B. THE MENTALLY RETARDED CHILD

Mental retardation is a serious handicapping condition that can occur in families who are advantaged in other respects as well as in families in less fortunate circumstances. In many sections of the country parents of retarded children have formed associations to be of mutual support to each other and to secure appropriate educational programs for retarded children. How a retarded child will grow up and get along in the world depends on his potential for development, and on how that potential is fostered. Early in this century people felt that retardation was a hopeless condition; today people realize that whatever a child's potential may be, the way he is treated can make him better or worse. It is also true that the majority of retarded children are neither deformed nor socially unac-

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ceptable. With good education and warm relationships many can be trained to support themselves and lead useful lives.

When a retarded child comes to Head Start, it may be his first school experience, but it won't be his first learning experience. From the day he was born he has been growing and learning. Too often we think of retarded children as not developing, when in fact retardation is not an inability to develop but a slowness to develop. Actually what we are afraid of is the myth of retardation — the idea of a mental defective. In fact, most classroom teachers have had unlabeled retarded children in their classes.

Since many cases of retardation involve medical problems, careful medical examination is an important part of the diagnostic procedure. A careful evaluation of the social and developmental history of the child is also necessary to attempt to assess his rate of development. The clinician will also be concerned to find out whether there are some factors in his environment that can be modified to assist him in using his capacities better. The task of bringing up a retarded child is a difficult one and parents may need the help of both medical resources and social agencies.

Profoundly retarded children may often be unable to walk, talk, and toilet themselves. They are frequently institutionalized. They will not appear in Head Start classrooms because of their extreme retardation. Though the condition is a terrible tragedy for an individual child and his parents such profound retardation occurs very infrequently in relation to all children who are born.

Unlike the profoundly retarded child, moderately retarded children can usually attain many of the self-help skills that other children have, though they will acquire them more slowly and need more assistance in learning them. In their elementary school years, they are usually able to attend public school in special classes designed to teach some practical skills, and to provide the socialization that all children need. As the medical section of the manual indicates, there are many different causes for mental retardation. The variations in children's kinds of abilities, and even in their physical appearance, within the moderately retarded group is also quite great. They may have motor or language problems that are related to brain damage resulting from the accident or infectious processes that caused their disorder. Children with Down's Syndrome have the kinds of features (appearance of slanting eyes) that caused this disorder to be earlier labeled "mongoloid." Though most of these children have extremely low rates of learning, this is not universally true. An occasional child with Down's Syndrome is able to learn at a rate only somewhat less than that of more normal children.

Some children whose intellectual development is retarded are very attractive with no physical signs of difficulty in their appearance. Their difficulty may be apparent instead through very slow speech development, inability to follow directions, and lack of ordinary judgment.

The diagnosis of mental retardation is a serious matter and should not be made from single signs like slow speech development or motor awkwardness. We have even known of an upsetting and absurd diagnosis of Down's Syndrome in a little boy whose eyes looked somewhat different from other children's in the class because he had an ancestor of another race. A complete examination showed him to be a perfectly normal child, physically intact, with good intellectual capacity for his age. Careful examinations and periodic re-evaluations are important both to avoid error and to plan well for how the succeeding steps in the child's development can best be encouraged.

It is not surprising that a high incidence of emotional disturbance has been found among retarded children. Many have been found to be aggressive, severely withdrawn, or fearful. Sometimes the degree of emotional disturbance is so great that it is difficult to know whether the child's poor adjustment is primarily due to the severe emotional disturbance or to retardation as such. The emotionally disturbed retarded child, like other children, needs help with the emotional aspect of his problem, whether or not such help can be expected to alter his potential for intellectual development. When mental health facilities are available, every effort should be made to secure help for him.

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Retarded children with emotional disturbances, in addition to needing flexible teaching methods, like other emotionally disturbed children will need more adult attention in the classroom. Plans to have extra help available are necessary if these children are to be successfully helped in Head Start.

Most Head Start programs can accommodate without great difficulty an educably retarded child who does not have a severe emotional disturbance. When you are planning to include a retarded child in your class remember that the goal is to help the child reach the highest level of development, not just inclusion. So while it might be possible for you to manage the child full time, it is a good idea to see what other resources the community has available which offer special teaching for the retarded preschool child. Some areas have two-or-three-day a week preschool classes for retarded children; some have home stimulation programs. Sometimes it is possible to do both a specialized program and part time Head Start program. Then the child has the benefit of both. But when such special training is not available there are ways to help the moderately retarded child within the Head Start program.

Most preschool experiences and materials are designed to cover a wide age and ability span. The thoughtful teacher generally tries to lower her expectations appropriately for a retarded child, and when doing a complicated lesson uses her judgment and assesses the child's interest before she attempts to involve him. If she finds the lesson too complex for the retarded child, some of the younger children in her class may also find it beyond their present capacities. Hence she will probably want to have an alternate activity available as well as another staff member to supervise it.

The teacher will probably notice that these children may need a few words of extra explanation or another demonstration before they catch on. They may also need occasional extra reminders of classroom rules, warnings before transition times, or limited choices of things to do.

There is much the teacher can learn about the child's abilities by watching him in school. Don't hesitate to ask him whether he can do something, and don't be afraid to let him try something even though he has not done that particular task before. If the task is too hard, you and he will both know it. In that case you can say, "It's too hard for you right now – let's try it an easier way," or you can try something else.

Many retarded children develop healthy, engaging personalities. They are in tune with their environment and behave in a way that is typical for their mental age. For instance a four year old retarded boy who functions like a two year old may greet a guest in his Head Start classroom with a wide smile and a friendly "hi." He may or may not respond to your asking his name but he might well pull you over to the water table to have you admire his soap bubbles.

However, since retarded children live in an environment that is primarily organized for normal children, they are constantly exposed to situations which demand more than they are capable of. In such situations, a child may not have the proper understanding, judgment or impulse control and may find himself in trouble and feeling bad about himself. All retarded children find themselves in these binds occasionally and many learn to handle them by passivity, walking away, or stating quite directly "don't know" or "can't do." However, the child who constantly finds himself in such stressful situations builds up a feeling of failure, tends to distrust his own solutions and to ask others to do things for him that he could do for himself. He may clown, act unnecessarily babyish, naughty, aggressive, or passive and withdrawn in order to cope with his environment.

Occasionally other children may respond to this kind of behavior in ways that are difficult for a teacher to handle. They may constantly exclude the retarded child from an area or an activity, or they may tease or taunt such a child about his difficulties, especially if he is different looking. Some children who have trouble dealing with their own anger will decide that the retarded child is the easiest one to hit or push down because he won't fight back. Other class members with similar problems may join in.

It is up to the classroom staff to offer a child protection from these constant battles. It is often a very difficult situation and usually takes at least two staff members to do it. Some teachers find it helpful to enlist the aid of another more competent child to show the retarded child a skill which he lacks. This always should be followed with praise for being such a good helper. If a teacher can make kindness and assistance a positive classroom value, it may help the problem.

A severely retarded child should not be placed in a classroom with a preponderance of aggressive children. It is dangerous to the retarded child and creates a situation which is not emotionally healthy for the others.

It is generally thought that the more retarded a child is the more difficult it will be for him to adapt to the normal environment. Even so some moderately retarded children may have abilities in special areas, such as memory or imitation, which will allow them some areas of satisfaction in a Head Start class.

When dealing with difficult or inappropriate behavior with retarded children, most Head Start teachers will feel they need more free time themselves or more staff to supervise these children, to remind them of the rules and to

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find alternate less stressful activities. It is necessary also to have a flexible classroom where more than one activity goes on a time. That allows for the retarded child to find a suitable substitute material easily and unobtrusively.

There are many books that spell out ways of teaching specific tasks to retarded children and other books that give suggestions for appropriate curricula. Such books are helpful, but you can organize your own curriculum and teach specific tasks effectively without them, if you remember some of the basic principles of teaching anything new to anybody. With retarded children you may find that there are some differences in emphasis, but it is only the special emphasis you need to learn, not a whole new system. Not all teaching is done by specific lessons. Much teaching is carried on in informal ways, as special needs arise. The following outline may help you to organize a lesson.

I. What Do You Want to Teach?

Everyone needs to acquire skills and information that help him to become more independent and to get along better in the outside world. The curriculum for a retarded child should be designed around self-help skills and basic information that will have practical value for him. It must also take into account the individual needs of the child. It is a good idea to build on the child's strengths rather than to hammer away at his weaknesses.

After you have assessed what the child already knows, you must decide what to teach him next. Two factors are all-important here: (1) his motivation, and (2) his readiness.

A. Motivation

What is the child interested in learning to do? Retarded children usually make their enthusiasms known either directly or indirectly. If you watch the child in class, you can see which things he chooses to do and which things he longingly watches other children do, that he might wish to do also. Is there anything you do that he imitates? If you actually jot these observations down, you may find you have quite a list. That's fine because it gives you a lot of ideas to work with.

If the child does not seem to be giving you direct or indirect clues about his desires, you will have to choose for him. Very often your relationship with him will encourage him to learn what you are teaching. The desire to please someone is one of the strongest motivations for learning.

B. Readiness

As with the normal child, the easiest way for a retarded child to learn is to build skills one upon another, beginning with the easiest and ending at the most difficult things of which he is capable. Readiness depends upon where the child is on the developmental ladder. If you have watched a baby develop, your own or someone else's, or read a book on child growth and development, then you know something about the way people grow. You know it makes sense that if a child has mastered a one-piece puzzle, perhaps it's time for him to try a two-piece puzzle. If a child already feeds himself well with finger food, then why not try a cup? If he can use a cup, why not a spoon? If a cup and spoon and fork, then why not learn to spread with a knife, and so forth? Knowing where the child is on the developmental ladder will help you teach at the appropriate level. The appropriate level is the level that:

a. uses skills the child already knows
b. provides a little challenge
c. allows for only a tolerable amount of frustration
d. provides for some immediate success.

II. Breaking Down the Task

Most tasks are larger than you think and more complicated to learn than you may realize. Even something simple may require breaking down into sequential steps, so a child can learn one step at a time and feel a sense of accomplishment.

Teaching a retarded child a simple skill should be spread over a period of time. It should be done one step at a time or one concept at a time. The learning experience must deal first with real objects and events. The child should be able to experiment with the materials which you are using. Also, the experience should be labeled for him, using simple appropriate words. There should be lots of time to repeat the activity until it is mastered. Once it is mastered, remember to let the child use it again in its original form. Remember also that you can incorporate several skills using one material or you can expand one skill by using different materials.

Most teachers have their own teaching styles and favorite equipment. One teacher developed the program shown below for teaching children how to use a slide. Another teacher felt she would have started with a classroom inclined plane because it was smaller. In any case, it is offered here as an example of how one might think about developing a day-by-day program which teaches a skill and is spread over a certain amount of time.

1. Place the child on the slide about one-third up and hold him as he slowly slides to the bottom. Let him get up at the end. Praise him.

2. Repeat the first exercise if he is still shaky, or place him higher up on the slide if he seems confident.

3. Place him on the slide as in #2 but let him slide by himself.

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4. Let him repeat #3 so he can begin to feel comfortable with the new motion.

5. You will still be putting him on the slide as in the previous stages, but first have another child demonstrate how to slow down by pressing against the sides of the slide with the feet. If he can't imitate the demonstration you may need to spread his legs for him until he gets the hang of it. Don't forget the praise.

6. Repeat the braking demonstration if necessary or let your pupil practice braking until he seems to feel completely comfortable on the slide.

7. and after. Teach him to climb the ladder. First have him grip the sides and step up one rung and step down one. Repeat, moving to rung 2, then to rung 3, and so forth until he gets to the top. Chances are he won't be alternating his feet on the ladder yet, but that's O.K. When he gets up three or four rungs, you may want to climb behind him to keep him feeling secure with the height. Ultimately he will get to the top. While he's learning to climb, you will want to give him some chances to climb again by putting him on the slide yourself. In each session you might put him a little higher for a longer slide. Finally the big day will come when he gets to the top. At this point you will need to stand right behind him to help him unscramble his feet to sit down. This movement is a little tricky the first few times for all children, but by then, the sliding down will be easy for him.

III. Encouragement and Reward

All children need encouragement to try new things and praise when they succeed. Most teachers provide a certain amount of this kind of encouragement and praise as a natural order of business. But because learning is more difficult for the retarded child, he usually will need more encouragement. Sometimes retarded children are worried about failure. Sometimes they are timid. Sometimes they feel they would like to do something but don't know where to begin. Encouragement always should follow immediately after a first trial no matter how tentative or small that trial may have been. Both the encouragement and praise should be immediate to let the child know what he is being praised for or encouraged to do, so that he will make a second attempt.

Praise from you is not the only reward. The fun of the activity itself is often its own reward. Doing things like other children is also rewarding. Being independent and grown up feels good; recognition of new skills by other children is exciting. Showing mother and seeing her pleasure is gratifying. Finally, making it possible to grow and learn in school is what Head Start is all about. The retarded child will sense this too.

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V. Management of Emotional Problems in the Classroom

This chapter deals with the behaviors characteristic of emotionally disturbed children and how the teacher can try to meet their needs. In this connection, it is important to remember that while emotionally handicapped children do not necessarily have either physical or cognitive disabilities, many, but not all, physically or cognitively handicapped children do have emotional problems. These may stem from the reactions of others and of themselves, to the physical or cognitive disability. In some cases, neurological difficulties associated with the physical disability can also contribute to the emotional problem.

A. INAPPROPRIATE BODY HABITS AND THE CHILD'S CONCERNS WITH HIS OWN BODY

It is not unusual for young children to develop certain kinds of body habits which are inappropriate for their age. Some examples are persistent thumbsucking, nail picking, nose picking, pulling on their own hair, or skin, and playing with their sex organs. Such habits may come and go, showing up only when the child is particularly tense or tired. But if they occur with great frequency and, especially if they seem to interfere with the child's ability to enter into the regular activities of the classroom, they should not be disregarded.

The most common of these body habits is *fingersucking*. Usually just the thumb is sucked, but some children suck two or three fingers. It is the young child's way of giving himself some comfort when he is tired, or frightened. Some children while thumbsucking pull on one of their ears, twist or pull their hair, or suck on a bit of clothing. Thumbsucking may also occur along with other body habits, such as body rocking. James, for example, after being scolded for knocking down another child's block tower, typically runs to a corner of the room, sits on the floor, and sucks on his thumb. He continues to watch what other children are doing, but for the time being he has to withdraw. Monica, on the other hand, in a similar situation, withdraws more completely. While thumbsucking, she hides behind a piece of furniture and covers her head with her dress, thus cutting herself off from the rest of the group. Monica's behavior pattern represents a serious form of withdrawal, while James' is more typical of the young child who is for the moment, troubled by his own or other children's aggressive behavior.

Body rocking and hair twirling may occur along with, or independently of, thumb and finger sucking. Tony, for example, often spends most of the morning sitting on the floor rocking back and forth, seemingly lost in a world of his own. When someone approaches him he usually just continues rocking. Sometimes he acknowledges the presence of another person, child or adult, by rocking faster, but at other times, he just continues the rocking as before. Typically, he neither smiles nor cries while rocking, though often he looks worried or frightened. Tony is a very troubled, insecure little boy.

While none of the three children described above does anything as part of the withdrawal pattern to hurt his (her) own body, Janie does hurt herself. Sitting quietly by herself she frequently pulls out her hair, one hair at a time. A bald spot is beginning to show up on her head. George, on the other hand, is more likely to pull out handfuls of his own hair with one hand and with the other to pluck at his arms or face. Children like these who hurt themselves are in special need of clinical assistance, as well as of the teacher's help.

What do these children have in common and how can the teacher help them? Most are lonely, frightened children who seem to anticipate that others will not accept them. So they withdraw from the group, seeking comfort from their own bodies. Often they secretively watch what is going on in the classroom, suggesting that they would like to become part of the group, but they don't know how to do so. They need the teacher's help and encouragement. Usually it is best to approach such a child slowly and to get down to the child's level — to sit or kneel beside him for a few minutes without trying to draw him out. With the teacher beside him this way, the child can usually begin to relate to her, to look at her and to respond to the alternative activities she offers him. These should preferably include either a quiet activity such as sitting beside the teacher or even on the teacher's lap, while she reads him a story, or playing alongside two or three children at the water table. Often these children can join a small group of children only after first having an opportunity to be by themselves with the teacher for a while in a quiet one-to-one relationship and only if the play of the other children involves neither completion nor cooperation.

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Since not all withdrawn children will respond in the same way to the teacher's attempts to help, she may need to try various alternative ways to reduce the child's reluctance to enter into group activities. A good rule to follow in general with these children is at any one time to offer the child not more than two alternative activities. To have to choose between more than two is very difficult for young children. On the other hand, if the child can tell the teacher what he would like to try, and if the child's choice is acceptable to the teacher, then this can be more useful to the withdrawn child than having the teacher present the alternatives. If the withdrawn behavior persists, despite the teacher's efforts, referral to the clinical team should be considered.

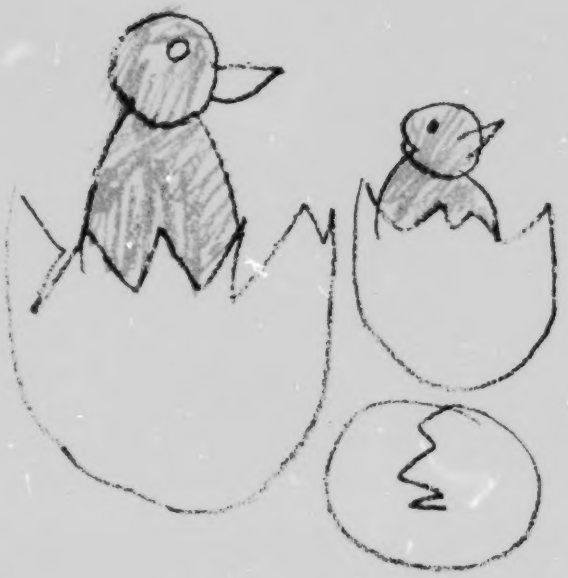
A further word about thumbsucking. Some parents fear that thumbsucking will harm the child's jaws and teeth. Dr. Spock's views on this should be reassuring. This is what he says: "If the thumbsucking is given up by six years of age – as it is in a great majority of cases – there is very little chance of its hurting the permanent teeth."

Ocasstionally children will *spit* at each other or at adults. Sometimes it becomes an enjoyable game to see who can spit the farthest. Though this is not to be regarded as seriously inappropriate behavior, it should not be allowed to go on. Usually if the teacher recommends a more socially acceptable game or activity the spitting will stop. On the other hand, an unstable tense child may persist in using spitting as a way of expressing anger and frustration. Susan, for example, often will come up close to a child who is standing or sitting nearby, and unless stopped by the teacher, will spit at this child. Susan uses spitting rather than words to attract attention, especially when she is tense and angry about something.

Breath-holding is rare in preschool children after the age of 4 but if it persists it is usually a sign that the child needs to be referred to the clinical team.

In general, body habits that are not physically hurtful to the child, if used occasionally and not accompanied by other troublesome behaviors, are likely to be given up with the friendly assistance of adults. On the other hand, self-hurting or extremely persistent, inappropriate body habits nearly always signify that something is seriously wrong.

Persistent wetting and soiling during the day occur in some preschoolers. Sometimes the child seems unaware of these lapses but sometimes they upset him very much. Kate, for example, after wetting, appears to be very frightened, apparently expecting to be severely punished. In her case, the wetting seems to follow either her inability to have her own way or seeming accidental or purposive hurting of another child.



Sometimes persistent wetting occurs because of a urinary or other type of infection. It is advisable, therefore, to recommend that a child who shows these behaviors be given a thorough physical exmination to determine whether there is a physical basis for the difficulty. On the other hand, the wetting and soiling may be related to psychological rather than to physical factors, as for example, the fear some children have of using the bathroom, especially in a new place. At the beginning of the school year, therefore, more children are likely to have problems with wetting and soiling than later on. On the other hand, fear of the toilet can continue on well past the early weeks and months of the school year. The toilet, with its loud swish when flushed, can be frightening to some children. Sometimes, the fear is tied in with the disappearance of their body products, when the toilet is flushed. The disappearance may be experienced as losing an important part of the self. Indeed, some children are terrified by the possibility that they themselves may one day be flushed down the toilet, intentionally or by accident. Such fears are common at the beginning of toilet training. By the time children enter preschool most children have conquered them. Yet a few children still are troubled by them.

Sometimes these children need the mother's permission to use the strange bathroom. Having the mother come to school and reassure the child that it is all right for him to use the school bathroom can help. Sometimes the child's

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problem centers around the need for more privacy while using the bathroom, especially if modesty has been stressed at home. Having several children using one school bathroom at the same time can be hard on such children even when each toilet has its own door. If the toilets do not have doors, the child may refuse to use them throughout the school day unless he can in some way improvise a door. Joanie, for example, solved her need for privacy by asking the teacher to be a door for her. Whatever the reason for the wetting and soiling, mothers should be asked to leave extra changes of clothing which can be kept in the child's cubby.

Young children occasionally make a habit of eating inappropriate substances such as chips of paint, pieces of chalk or even paper. The technical name for this is *pica*. While pica is not necessarily a sign that the child is seriously disturbed, persistent eating of inedible substances can be injurious to the child's health. Persistent eating of flakes of paint, for example, can cause lead poisoning since many paints still contain a lead base. If the teacher knows that a child has been eating paint, she should recommend that the mother should take the child to a physician.

Severe forms of pica occur most frequently in neglected children whose general physical condition is poor. Ernie is such a child. He is thin, pale and very undersized for his age. Throughout the school morning he is likely to swallow a great variety of inedible substances - chalk, paper, crayons, etc., along with the snack foods (crackers, cookies and cold cereals) provided by the teacher. The neighborhood worker reports that Ernie has shown this type of behavior at least since he was two years old and that he now has frequent digestive upsets. In school, Ernie is clearly a loner. Without the teacher's help, he does not interact with other children.

How can the teacher and the neighborhood worker help such children? Consultation with the mother is a first step. At home, as well as in school, providing the child with edible substitutes such as gum, hard candies and cookies, sometimes helps for the time being. What they typically need for the long run is a more favorable environment for growing up, i.e., one in which proper food and adequate supervision and training are available. If the pica persists, however, referral to the clinical team is advisable. With severe pica immediate clinical referral is advisable. If a child occasionally eats inedible but not harmful substances, this can usually be handled by the teacher with the mother's help.

Sex play which takes the form of interest in what other children's bodies look like, especially the sex organs, is common at this age and is usually an expression of the child's concern with how and why boys and girls are different. One way in which this interest expresses itself is in the so-called "doctor games," where children take turns in "taking temperatures," thumping on chests and otherwise examining each other. Pulling down pants and taking a look is not unusual at this age. It is likely to be done in secret; i.e., the children go into a corner, behind doors, or into an empty room, apparently realizing that they are doing something adults do not approve of. When a teacher sees such behavior she can help the children turn to acceptable activities without making them feel guilty about the sex play, if in a firm, but not angry voice, she says, for example, "I know you'd like to find out more about how boys and girls are different, so let's talk about it." Talking about sex with children can be difficult not only because of the teacher's own reluctance to discuss such matters, but also because of the uncertainty as to what mothers are willing to have their children know. The way to deal with this latter point is for teachers to consult with mothers early in the school year to learn how the mothers would like the teacher to handle sex talk, sex play and sex information. Children do need to have their questions answered, but in a way which does not conflict with parental and neighborhood values.

It is important to remember that curiosity about sex differences is normal in young children, as is also the fear that something may happen to one's own sex parts. The little boy may need reassurance that his penis will not fall off, the little girl that girls do not have a penis, that girls are fine without penises because they have other things. Such reassurances help dispel the boy's fear that he is in danger of losing a part of himself, and the girl's fear that since she has no penis she is damaged. Letting children express these fears openly is likely to cut down on the sex play.

Questions about where babies come from are common at this age, but there is usually very little interest in a detailed account of the "facts of life," as the following incident demonstrates: Five year old Johnny came rushing into the house to ask his mother "where he came from." Thinking that Johnny was asking how babies are made, his mother somewhat reluctantly told him about the birds and the bees. When she got all through she asked Johnny if he had any questions and Johnny said, "Yes, Freddy says he comes from Philadelphia, where did I come from?" Clearly, Johnny was not asking for the "facts of life" and most children of this age are not ready for a detailed explanation. One way to avoid giving too much, too little, or the wrong information in answer to the child's questions is to ask Johnny why he is asking the question, why does he want to know?

A common misunderstanding of young children has to do with where in the mother's body the baby grows. Since

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the stomach area of the mother becomes more and more distended as the pregnancy progresses, it is not surprising to find that children assume that this is where the baby is growing. Since even young children associate growing fat with eating a lot, some children develop fears around eating when they come in contact with pregnant women. Explaining to the child that the baby grows in a little sack separate from the mother's stomach can be reassuring to the child. Another fantasy children sometimes have is that babies are born through the rectum, the same place where bowel movements occur. Bowel movements then can take on a special meaning for children, that of giving birth, and as such can be very frightening to a young child. Such fear can result in the child's withholding his own feces, thus serving as the foundation for chronic constipation. Moreover, since feces are usually regarded as dirty, these children are more likely to accept the view that sex itself is "dirty." Simple, straightforward explanations about where babies come from can help the young child give up troublesome fantasies. For further suggestions on how to answer children's sex questions, see, for example, Dr. Salk's book, *What Every Child Would Like His Parents to Know*.

Many children, both boys and girls, sometimes hold on to their sex organs when they need to urinate. It is as if they want to hold in the urine and thus avoid having an accident. When the teacher sees this behavior it is appropriate for her to say, for example, "Do you need to go to the bathroom, Johnny?" Sometimes the child does not go to the bathroom when he needs to because he is involved in an enjoyable ongoing activity either alone or with other children. A simple statement by the teacher such as "you can go on with your game (or whatever) after you go to the bathroom" will usually help the child interrupt his play long enough to go the bathroom.

Sex play in young children sometimes goes beyond the so-called "doctor games." Amy, for example, tries to peek under other children's dresses, while Henry often keeps one hand inside his pants as he sits gazing out of the window or even while walking around the room. Sometimes he appears just to be holding his penis; at other times he takes his penis out and openly masturbates. Henry may be trying to reassure himself that his penis is still there or, more likely, he is worried and tense about a lot of things and needs somehow to work up his worries. Rubbing the penis can serve this purpose since it gives him some body pleasure. How can the teacher help Henry? Many adults would be tempted to threaten Henry — to tell him, for example, that his penis will fall off if he keeps on playing with it, or that he'll make himself crazy. Such threats will not help Henry. First of all, they are not true, and second of all, they are likely not only to make him worry all the more, but also to instill additional fears of anything associated with sex. Since excessive handling of the sex organs is usually a sign that the child is worried about something, yet society disapproves of such behavior, the teacher may say to Henry in a matter-of-fact way that he should try not to do it anymore, that most boys and girls want to do it sometime or other, but they can usually stop if they try. If this approach does not help, it may be necessary to get at what the child is worried about. Henry may be able to tell the teacher about his worries, especially if she sits down quietly beside him and encourages him to talk. But sometimes the worries are too frightening to the child and he cannot really talk about them. These children should be referred to the clinical team. Dr. Spock, for example, tells us about a little boy who was terrified that his sick mother would die. The child, unable to concentrate in the classroom, absent-mindedly began to handle his penis more and more frequently. Talking out his fears with a member of the clinical team helped him to give up the habit.

B. THE AGGRESSIVE CHILD

Young children deal in different ways with wishes to hurt others and to get what they want. Sometimes we see children shoving and pushing other children just to show how big and powerful they are. In relation to parents and other grownups, all young children are little and sometimes they like to try to show by their physical behavior that they are not the littlest and least powerful. Occasionally they behave as they did when very young to show they can get what they want or to show how angry they are when they don't get it. They may once in a while bite other children, more often grab things, or knock over toys other children are playing with. When children consistently behave in one or more of these ways, we are likely to regard them as *aggressive*.

If the children have reasonably good relationships with their parents, besides wishing to show how powerful they are, young children also very much wish for the approval of their parents. When they get to know and like their teacher they also will want her approval. Expressions of disapproval for hurting other children, interfering with their play, or grabbing things will ordinarily lead to a gradual reduction of these behaviors. This is especially likely to happen when the teacher offers a substitute way to feel important. If she suggests that he build a block structure of his own, and admires it as he builds, he may be distracted from knocking down another child's blocks. We all know that this may not

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happen the first time and that the teacher may have to try many times to show the child what behaviors she admires and what behaviors she does not.

Even the child who is progressing normally in the socialization of his aggression may have rivalries with his brothers and sisters at home that make him on some days less able to cope with sharing adult attention and toys in school.

Preschool teachers know that they will have to cope with occasional undesirable behaviors in many of their children. In the classroom itself, situations of real frustration are bound to happen. When there are not enough magic markers for everybody, and everybody decides he wants one, when a heedless child has stepped on a painting left to dry, the child who doesn't get what is his share, or the child whose product is damaged will experience some natural anger. It is then that children whose control of anger is not very secure may hit, nip, or kick another child, until the teacher can step in as one who will decide how to remedy the situation.

Some children come from crowded neighborhoods where it is difficult for mothers to supervise the children's play. Often the amount of hitting and grabbing is greater in these children. As one project mother reported, "There are so many children playing there that she has learned to grab her own toys first when she falls and to tend to her hurts later. Possession here is nine-tenths of the law." What the children have to contend with in their other play groups is something the teacher has to take into account. She may not agree with the other group's way and she may plan to have her own class act differently, but she understands what the neighborhood situation is like and she will know that it takes time for children to catch onto what she thinks is the appropriate way for them to get along with each other.

What really worries the teacher is the child who is not responsive to her expressions of disapproval or to her praise, he may seem to enjoy her praise but over a period of time not change his behavior very much. Children vary in how they control their hostility within the classroom. Sometimes when the teacher has more than one child in her class with a serious tendency to hurt other children, there is so much trouble that she has a hard time to see how it happens. If she and her assistant can compare notes at the end of the day, after a while she can usually see some pattern to the troubles.

These are some of the aggressive patterns we have seen. There are also other patterns. Sometimes a child really hurts another child for a very small thing. Sometimes the teacher is aware of why the child is angry, but sometimes

she is not. In Ann's case, the reason was not at all clear, at least not in the beginning.

Ann was a pretty, little blonde girl who at first had some difficulty leaving her mother but very soon wanted to come to school. When she arrived in the morning, she sometimes had scratches or bruises on her face that looked as if she could have been fighting with her older sister or brother and got hurt. In class she was peaceable and friendly with other children when she had what she wanted, but if another child was using something and did not give it to her at once she bit that child. Sometimes it was not just a little nip, but a real bite that broke the skin. The teacher then had to send the bitten child to the clinic since human bites can result in an infection. Ann was often in angry tears both because the teacher reprimanded her and because other children looked at her with disapproval. Sometimes in addition to biting, Ann would also hit and throw things. After some particularly hard times, Ann's mother had to be asked to keep her at home for a day, partly to give the teacher and the class some relief, and partly to make it plain to Ann that in school she had to try to control her biting and hitting. With a great deal of affectionate attention when she was not hurting other children, both

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from her teacher and from volunteers whom the teacher asked to pay special attention to Ann, the intensity of the biting diminished, but the ready nip was for a considerable part of the year her method of trying to get what she wanted. Later in the year spells of prolonged crying became more frequent than the biting. As she grew attached to the teachers, the sadness that had been covered up by the aggression came through. The neighborhood worker who had maintained contact with the family found that mother herself was depressed and had little energy to put into the management of her children. In her struggle to maintain herself in the family group Ann was frightened and demanding and used her teeth as a weapon to try to get things for herself. Because Ann's problems remained so persistent, a clinical evaluation was recommended.

In addition to the teacher's concern that the aggressive child not hurt others, there is also the concern that nonaggressive children will begin to imitate the aggressive child. It is essential, therefore, that the teacher be able to set clear limits. Otherwise, several members of the group may become aggressive. For example, if the teacher is not able to limit the use of biting or hair pulling by one child, others of the group may also try it out. It may start as "doing it back" to the aggressor but then be used more generally particularly to plague more helpless group members. Grabbing other children's things and refusing to take turns also belong in this "contagious" category though they are not quite so difficult to manage. Children are not too likely to adopt the clearly bizarre behaviors of a disturbed child, but the destructive behaviors that were natural to children at an earlier age level have a particularly contagious effect.

The most severe and repetitive aggressive behavior is often seen in children who have been frightened in their own families or neighborhoods and are determined to reverse the situation, that is, they wish to make other children afraid of them. This presents the teacher with a particularly difficult management problem since when such children become more frightened, they frequently become more aggressive. Threats of severe punishments usually only make the difficulty worse, if they are effective for the moment they are not in the long run. They can add to the reservoir of fear and anger in the child that will explode again. What we have seen work with children who are not too angry or disorganized is a teacher speaking in a firm voice and temporarily removing a child from an activity. This works when the teacher is pleasant with the child at other times, i.e., when the teacher and child do not become enemies. Children who often have difficulty with managing their hostility are liable to have *temper tantrums*. These usually do not look like simply going after another person to hurt him but like a general discharge of rage which may also involve hurting someone. What teachers usually think of as temper tantrums are times when children throw everything within reach, kick or flail about without caring whom they hurt, or lie down on the floor kicking and screaming, or run about screaming and hitting anyone in their way.

When the child kicks or bangs objects but does *not* hurt anybody, the situation is easier for the teacher to cope with. Sometimes if she can intervene quickly she can console the child for feeling so miserable, find out what's the matter, and stay near him until he has calmed down. At other times he needs to be removed from the classroom and have some time out on a one-to-one basis because he is too disorganized to respond to anybody with anything except more anger. He needs time to quiet down.

Sometimes the child in a temper tantrum hurts somebody because he wanted to. But sometimes another child gets hurt merely because he happened to be in the way. Thus, when aggression occurs, consideration should be given to (1) the child himself, (2) the one who has been hurt, and (3) the group of other children who may be frightened by the intensity of the outburst. Since there are usually only two grownups in the classroom, they usually will find it helpful to divide their attention, one tending to the child who was hurt, and the other to the child in the tantrum. If the hurt child is not badly hurt, the teacher who tends him may be able to move him back into the group as she consoles him.

The teacher who tends the child in a tantrum would do well first to try to speak to him, to see if she can calm him down. But often this is not enough. The child needs to be physically restrained and moved away from the group. If a room is available adjacent to the classroom (and we wish one always were) the teacher can take the child there. If not, she may have to take him to a corner of the classroom. Reproaches and scoldings usually will not help at this point since the child is usually too angry and disorganized to listen. Consolation is the first stage in restoring most children to their more reasonable selves. "I know it feels terrible to be so angry; I'm sorry you feel so bad," etc. A little later when the child is calmer, the teacher may or may not be able to find out what he is so angry about and see if it can be remedied. After the teacher has allowed him to verbalize his anger she still needs to give him time to recover before she can safely expect him to rejoin the group.

One reason for removing the child in the temper outburst from the rest of the class is that his behavior can be a threat to the controls of the others. The outburst may scare the others, who then start acting more babyish than

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usual if they have to be near him while he cannot control himself. The class often needs some simple report from the teacher about what has happened to Johnny, e.g., "Johnny got too upset when Sue took his truck. We have to help him not to do that. Sue is OK now, but we're sorry he hit her."

When the child who is the victim is in fact badly hurt, other things need to be done. Other personnel (teacher in the next room, cook or bus driver) may have to be asked to help while the teacher either calls the mother or takes the child to the clinic herself. (Like any emergency or accident in which a child is really hurt, the procedures for getting physical assistance need to be worked out at the beginning of the school year.) In the meantime, the rest of the class needs the presence of an adult and some information to indicate that the teacher is taking care of things.

Taking care of any angry child who may hurt others is a very stressful job, and if the child is angry a great deal of the time it is hard to like him. A teacher can find herself being glad for the days he is absent, and dreading the days when he comes to school in a bad mood.

This makes preventive action in so far as possible of considerable importance. The teacher's observation of the circumstances in which the child tends to get angry and her maintaining an interest in him at those points is important. If she recognizes that transition times like coming into school, going out to the playground, or waiting for lunch to be served are particularly troublesome times for one child, she will attempt to maintain eye contact with him at those points or ask her aide to do so in order to intervene before the child gets too upset.

Some children have a particular interest in a fight with one other child in particular. In so far as possible she can attempt to interest them in separate activities. Other children will use an aggressive act to get themselves some interpersonal contact when they feel left out. For example, when two children are playing comfortably at the water table, one may grab the container they are filling or shove the other one hard out of the way. It is tempting to label this behavior as "attention-getting" and think of it as just bad behavior. But we really know that all children need attention, and that some do not know very good ways to get it. If the teacher or her assistant can spend a little time with the aggressive one, she can sometimes help him to learn how to get into the play without hurting anyone. She can show him how to build in the block corner a road to go with the building the others have started or to help find all the big blocks for the giant building she will help them make. Feeling left out is one of the most painful feelings for children, and the child who has just begun to learn social skills can easily become isolated by his own aggressive maneuvers if these are the only ways he knows.

The sources of excessive aggression are outside the classroom, and the teacher and the neighborhood worker will naturally discuss what can be done about the things that are keeping the child angry and upset. Nevertheless the child very much needs the socialization of the classroom and the teacher needs to plan especially carefully how to teach such a child some of the ways to manage himself in relation to other children.

C. THE HYPERACTIVE CHILD

Children show a wide variety of activity levels within one classroom. Often in dealing with preschool children, a teacher may feel as if she plays the part of a traffic policeman. She stops some activity; she starts another. She slows down the runners and hurries up the dawdlers. Such monitoring of motion comes naturally to most and it is part of the daily job. However, often a teacher finds herself on one child's back constantly because of his restlessness, his wiggling, his inability to keep his hands off other children, his constant talking, and purposeless running back and forth. Children who are constantly restless and who are active in a purposeless way when they play, sit, watch TV, ride in a car or rest are often labeled hyperactive, overactive or hyperkinetic.

Many studies show that 3 to 4% of our nation's children are labeled hyperactive. Ninety per cent of them are boys. We don't know the reason for the high percentage of boys. We know it is not usually hereditary. It occurs in about the same numbers among all races, all cultures, and all socioeconomic groups.

People have asked repeatedly: what causes hyperactivity? As far as anyone knows it is not caused by one specific thing. Some children react to anxiety by becoming overly active; others may have some minimal or mild brain damage. We know that all children have different developmental patterns. This is true for hyperactive ones as well.

Some mothers have reported that their children were active and excitable from birth. They cried, moved constantly, slept little and had prolonged colic. Other mothers noticed nothing unusual about their infants until they began to walk. When they walked they ran, climbed and got into things. They turned quiet, organized households into chaos; ordinarily calm parents became screaming disciplinarians. Still other more tolerant parents only found that their children had trouble when they entered kindergarten or grade school.

Most parents try hard to cope with the situation at home by trying to keep calm and hoping the child will outgrow

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this phase. Eventually parents of those who do not outgrow the problem recognize its seriousness and seek diagnosis and treatment.

Medication is sometimes prescribed by the child's physician and may be useful in helping children become more calm and better organized, especially when it is used in conjunction with improved home and school management. Some children have only minor improvement with medication and others seem to derive no observable benefits. If a child in your class is taking medication you should know what the name of the drug is, how much he takes and how often he takes it. If there is a change in dosage or frequency given, you should also be alerted so that you can watch for behavioral changes. Conversely, if you notice a drastic change in the child's activity level, appetite loss, clumsiness or slurred speech, you should report this to the parent, who may ask you to convey the message directly to the doctor handling the child's medication.

Deciding whom to consult is often a difficult decision for families to make. Some people begin with a thorough history and check-up by their family doctor or pediatrician. Others want the opinion or a second opinion of a specialist familiar with the syndrome of hyperactivity — either a pediatric neurologist or a psychiatrist.

Anxiety and stress will always increase hyperactivity. Often teachers will notice raised activity levels before or just after medical exminations, the arrival of new classroom personnel, or separation from their mothers in the morning. A problem at home will also reflect itself in a child's school behavior. If you notice an increase in activity or anxiety, it helps to ask a child if there is something bothering him at home. It is also a good idea to ask the neighborhood worker to make a home visit to see if she can help the home situation.

Children who are hyperactive may have other problems which affect their classroom functioning. They are:

1. distractibility
2. short attention span
3. constant repetitious purposeless motions, e.g., hair twisting
4. inability to sit still
5. problems in following verbal directions
6. constantly touching other children and their things
7. aggressiveness brought about by attempts to constrain
8. seizures
9. accident proneness
10. frequent mood shifts
11. impulsiveness
12. clumsiness
13. problems with fine motor coordination
14. inability to wait for things

Not all children who have these additional characteristics are hyperactive; some of these can occur with immaturity or transient anxiety.

Classroom Management

Some classrooms adapt themselves very easily to the hyperactive child. These are usually classrooms which are fairly large, well-organized, do not contain a lot of clutter, and which have some sort of permanent indoor climbing equipment, or separate noisy/active room.

What happens if your classroom doesn't fit the above description? Can you handle a hyperactive child in your class and make it a positive experience for him and for the other children? In most instances reasonable adaptations can be made which allow you to accommodate an overactive child without too much disruption.

SPACE

One of the primary needs for a child who is extremely active is space to move about. The space you have may not seem large at all, but could you use it better? Here are some ideas that have been found useful for teachers in small classrooms:

1. Use wall space for storage and tempera painting. This eliminates the need for easels and some book shelves. Wall storage may often be made cheaply by stacking and glueing large cardboard tubing or quart bottle soda cases on their sides.

2. If table space which accommodates everyone simultaneously is only needed at lunch time, collapse folding tables, or stack non-folding ones top surfaces together, legs up. Chairs, too, can be stacked when not in use. Most children can learn to do this easily.

3. Movable low partitions help delineate small areas when they are needed, but allow you to open up a large space quickly. Book shelves are best for this. They are not tippy and not too easily moved by children.

INTEREST SPAN

4. Always have some toys out available to everyone and other things put away. This reduces clutter which confuses hyperactive children. Varying the toys available creates interest and is one way to extend few materials.

INABILITY TO SIT STILL

5. At the very beginning of school make it clear to all children which exits they may use to go to the playground

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or to other parts of the building and when they may leave the room. Repeating this carefully and firmly until all children understand it may help you keep track of wanderers, and cut down on the amount of chasing you need to do.

6. If possible, provide for some sort of indoor climbing equipment. Climbing apparatus may seem bulky and distracting to you if you haven't been fortunate enough to have had any in your classroom. However, some are bulkier than others. Some take up relatively little floor space but use lots of vertical space. Some kinds of jungle gyms have attachable slides or side pieces which you can use when you do have the space, but they do not need to be available everyday. One piece of equipment that is collapsible, takes up relatively little space, and costs little is a balance beam with a low sawhorse or two. This makes a seesaw, a small slide for sliding down or struggling up, a ramp for cars and tracks, and a walking board. The versatility of this material makes it appealing to chidren.

7. Make better use of your outside play yard. You may find that two short outdoor times work better for your class than one. While outside vary the activities. Add some simple running games and exercises to your repertoire. Bring a large ball one day. Another day get out the tricycles. Still another day go for a short walk. In the springtime or early fall, digging and water activities are fine.

IMPULSIVENESS

8. Provide other soothing and absorbing materials. Equipment that provides a tactile experience usually works best. Sand boxes, water tables, salt trays, shaving soap dispensed by the teacher for finger painting on table tops, bubble blowing, or sink water play are some that most children like best. Vary these kinds of activities every few days, so that they keep their appeal.

9. Have some place like a quiet corner where a child can go to calm down or see what others are doing. Teaching hyperactive children to take time out to look around and decide what to do next is a valuable way for them to learn to handle their problem. You will need to suggest and accompany them the first few weeks but if it is a useful place, eventually they can learn to use it if you remind them.

10. On rainy days see if you can use an auditorium or gymnasium. If neither of these is available, you could use a hall for some running games. Be sure to have a teacher at each end as a "stop sign." Halls also accommodate tricycles and wagons well in a pinch. Jumping games, follow the leader, and Simon Says will help you utilize this space in a quieter way should you find that noise is a problem. Halls lend themselves well to parades, either musical or dress-up.

FOSTERING CONCENTRATION AND SUSTAINING ATTENTION

Just having the proper space is only one hurdle. Teaching active children when and how to use it to control their behavior is another.

Hyperactive children can and do sit down and concentrate on some quiet activities. Of course this should be encouraged. Their attention spans are shorter than average. Because of this they cannot sit still as long as the average child. They need the chance to get up and move about in a socially acceptable way when they have done all they can.

How do you know when a child has been inactive for as long as he can manage it? You won't know what the child's limits of concentration are the first day or even the first week. First you must establish how long he can work without leaving the situation or disrupting the activity. After a certain amount of clocking, you will begin to anticipate the hyperactive child's need for change. Just before you think he needs a break, it is a good idea to move over to him quietly and suggest that he run off some steam in some way that is permissible. That way you are telling him that you understand his problem, that there is an acceptable solution, and that you care about him and will try to prevent his getting into trouble.

Hyperactive children can be encouraged to work longer at quiet activities. Once you have some idea of their capacities, you can often help them to extend the time and interest in a favorite toy or activity, by stepping in just before the child would ordinarily make a transition to doing something else and helping him stay with the original item. How do you do this? One's first impulse is to have the child keep going as he is. But usually it works better to change the activity just a little bit, by adding something new to what he is already doing. For instance if the child were making a collage you might help him continue his project longer by stepping in just before he was about to get up and leave, and offering him a bit of tin foil for his picture. If he takes it and glues it, and you admire what he has done, he has probably stayed with his work a minute or two longer than he would have without your help. If you consistently encourage his staying with something just one or two minutes longer over three or four weeks, he may be able to manage that extra time soon by himself. Another way to keep a child going is by verbal interaction around what he is doing. You might praise it, ask a question about it, show it to another child or sing a song mentioning it. We are talking about one or two minutes here. That may seem like a lot of work for the teacher to do for very little improvement, but those small bits of extra learning time add up over the year. Usually it pays off.

When you first begin making these observations you may

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feel that the child gives no warning before he leaves an activity or disrupts. Actually for most hyperactive children this is not so, it just seems that way. Usually there are signs of impending movement. They are subtle, and vary from child to child, but the most frequently noticed ones are a fleeting impish grin, a distant hazy look, a slight crossing of the eyes, or a glance to a distant part of the room. Once you have been able to pick up some of these warnings you can move in and help the child make a transition before it is too late. Once you have discovered the warning signs don't keep the information to yourself. Share it with the child. Often if this is repeated to him he will begin to understand these inner physiological tensions which precede his dashing off. Once he can grasp these feelings and recognize them as warnings, sometime he will be able to make an appropriate transition to a more active kind of play himself.

Although such observation and management is not easy to do and certainly is time consuming, if you are able to do it at the beginning of the year, it will cut down substantially on the amount of policing you need to do. Helping the child manage his problem in the healthiest way he can is one of your goals. It is time consuming and takes a certain amount of both dedication and consistency. It is easier for some teachers than others, just because it fits in with their natural styles of teaching. It helps if the teacher has a fairly high activity level. Teachers who have an ability to tolerate a fair amount of noise and motion often find that hyperactive children do well and cause little disruption in their classes. Teachers whose chief interest is in outdoor or active play, or teachers who find it possible to run a program which allows for several choices of activities, may like having an overly active child in their classes. Other teachers may find hyperactive children a difficult drain on their energy supply. In order to avoid getting tired, and hence cranky, classroom personnel need to work out consistent ways of managing the child so that they can help each other. As one begins to get tired, another one steps in to take over. If one teacher begins to find herself not tired but angry at the child it is a good idea for someone to step in as relief for a little while.

Praise has been mentioned frequently throughout this section because it is one of the most useful tools in the management of hyperactive children. We know that all human beings like to be praised, but approval and praise mean more to hyperactive children because usually they don't feel as good about themselves as others. Why? Most of these children have been constantly reprimanded for their disruptive behavior. They begin to feel that there is nothing that they do that is right. If you as a teacher can begin to help them learn to conform to school expectations in a small way, and allow for the times when they cannot behave like others, and give them chances to run off steam in acceptable ways, eventually they will feel better about themselves.

When you praise a child give small amounts frequently. Be sure to let the child know that he has done something well, or managed his behavior well at the time he is doing it. That way he will know exactly what it is he has done right. Vast amounts of empty praise do very little.

Almost everyone who has taught hyperactive children has found it discouraging in the beginning, then a challenge, and finally very rewarding. Hyperactive children do benefit enormously from inclusion in a good nursery school program. It is possible with good management to see a significant improvement in their behavior.

D. THE WITHDRAWN CHILD

Jimmy never seemed to have much fun. You could see it from the look on his face, a little sad, but most of the time just blank. He didn't want to join the other children, and even when little Karen gave him some of her toy cars one day, he took them, but then wouldn't play with the cars with *her*. In fact, Jimmy didn't play much at all. Mostly he would stand around watching the others. If he did try the crayons, he gave up quickly. He rarely spoke, and for a long time the teacher wasn't sure that he could speak. Finally, he began to whisper, "Teacher," once in a while when he needed help to go to the bathroom. All in all, Jimmy was a loner, not in the independent, active sort of way, but isolated and lonely.

The trouble with the withdrawn child is that he is no trouble at all — to anyone but himself. In a class that is likely to have its share of noisy, running, grabbing or pushing youngsters, the teacher may at first see the withdrawn child only as a child who doesn't get into scrapes, or add to the demands the group makes on her. On closer or longer observation, however, she may begin to notice other things.

Sometimes children like Jimmy find special ways to make themselves feel better, less lonely, less frightened. In these special ways, they try to give themselves the comforting feelings that most children get from being with others. So, sometimes you may see such a child spending long periods curled up in the rocking boat, or repeating over and over some simple activity, like building a tower and knocking it down, or continually handling himself. Perhaps he has the habit of putting things like play dough, paste, or paper into his mouth to suck or chew. Sometimes the child will slip a special toy into his pocket, not exactly to take home, but to make sure it's his. All of these

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behaviors have nearly the same meaning: it is the child's way of trying to comfort himself, to make himself feel good, because he has such a very hard time being friendly and outgoing with others.

Another kind of behavior seen in some withdrawn children looks less self-comforting and more self-hurting. Scratching, skin picking or lip biting may persist to the point of causing sores. The child may pull out his own hair until a bald patch develops. Such self-harming repetitive habits are signs of more serious difficulty. They show the teacher that the child is particularly tense and badly in need of expressions of warmth and protection from others.

Why should a child behave this way? Usually he is feeling lonely and frightened — not of something specific, but of what it means to be with other children. Some youngsters have not yet learned by the time they enter preschool how to feel relaxed and comfortable with other children. They do not really trust others, and because they can't make friends, they end up always feeling like a stranger or outsider. Sometimes these feelings amount to extreme shyness and the child will overcome them more or less naturally during the year's progress. But other times these feelings of fright run much deeper; the child may appear wrapped up in his own little world, may learn only *very* slowly to approach perhaps a single person in the room who seems especially warm and kind. (See section F of this chapter.)

What can the teacher do? First, she can realize that although a child like Jimmy is not a "troublemaker," he needs her attention every bit as much as the one who stands on the table and screams for her. Because withdrawn children do not make frequent demands, the teacher must remember to give on her own. She may make a point of smiling and talking gently even though the child shies away. She can offer herself as the link to help the child join others in the group. By joining him herself, by giving him materials to work with or by starting him on some activity with another youngster, she may be able to ease him into contact with other children. If he has been rocking in the boat all morning, she can suggest to another child to join him. If he is quietly eating paper, she can offer him a cracker. In these ways the teacher can try to show him that people can and will provide the caring and companionship that he is failing to get on his own.

A word of caution is in order here. It sometimes happens that as the withdrawn child improves and begins to play with others, he does it in a sort of backwards way. He may start copying the toughest boy in the class, or on his own he may start knocking things down or throwing things. It's like saying, "If you really like me, you'll play with me anyway." For a child who previously has been doing next to nothing in the classroom, this roughness is really an improvement. This is not to say that the child should be indulged, but the teacher should realize that he is at last trying to hold his own. This kind of youngster sometimes gets it into his head that knocking another child's block tower down is a perfectly fine way of inviting himself to play. So the teacher has to show the child how to be friendly, as by saying, "I bet if you showed Tommy your toy truck, he would help build a garage for it."

In some cases, a teacher's best efforts over many months may not break the pattern of withdrawal and self-stimulation. Then it is time for the teacher or neighborhood worker to make inquiries, to find out about the child's behavior at home, and possibly to seek outside help. But despite the possibility that outside assistance may be

needed, the teacher's careful observations will contribute much to the planning for the child like Jimmy.

E. SEPARATION AND THE DEPENDENT-FEARFUL CHILD

For many children, coming to school is their first experience away from parents for any length of time. But whether or not they've had a chance to learn that separations are normally followed by reunions, children of three to four years generally are still concerned about separation to some degree. They are not quite sure why adults leave or are absent, or what will happen to them – the children – in the meantime, or when the adults are coming back. These concerns affect many aspects of school adjustment.

First, naturally the entry into school is involved. Careful planning can soften the shock of separating from home and mother. Meeting with child and mother in advance, the teacher can assist in trying to make the first days easier. Hearing what school is like, visiting the class, knowing where mother will be during school time, knowing how he gets home at the end of the school day – all this information will help to answer most children's questions about going off on their own. Some children need more than this kind of basic preparation. A child may still be tearful or insist loudly on mother's staying. Or perhaps, the child lets mother go easily, only to become upset later on in the morning. Some children don't scream or cry, but just seem very hesitant or uneasy about joining activities. Any of these reactions may call for further attention to separation concerns in the classroom. The teacher can of course begin by trying to comfort and reassure the child that mother will return at the end of the morning. Pretending to call home on a play telephone can help, as may indeed, a real telephone call home if the mother is known to be there. Playing hide and seek games, where hidden things are found after all, may also be reassuring to a concerned child.

Even after the children have mastered their concerns about the initial separation from home, certain other situations may bring out similar feelings of discomfort and uncertainty. Teacher's absence from the room often does this. The wild classroom behavior may burst out in front of an assistant or substitute, or the teacher may return from her absence to a chaotic classroom. This is often the children's way of expressing their concerns about the teacher's absence. It helps if the children are told in simple language where the teacher is – "has a cold," "had to go visit her family," "is just out of the room to talk to Mrs. Smith." These brief explanations are understandable and consequently reduce the children's fears. Similarly, children will want to know why one of their classmates has been absent.

Other situations that may need the same kind of discussion and explanation include: before and after vacations and the end of the school year. In all of these situations, it is a good idea to tell the children whenever possible about what is going to happen and where people will be going. The idea is to give realistic information to offset any frightening imaginings.

Events of these kinds typically affect most children. But the teacher may become aware of how strongly a particular child is affected. Diane had difficulty entering the room morning after morning. She came in clutching her mother's hand. Her eyes were often full of tears. When the teacher greeted her, she buried her face in her mother's skirt. It was only after the teacher had chatted for several minutes in a friendly way and had offered her hand to hold that Diane allowed her mother to head for the door.

Once in the classroom, this kind of child may do a good deal of whining. The whining is saying, more or less: She needs teacher's help. Since she is a good girl, why can't she have what she wants? Will teacher sit next to her and draw with her? Will teacher scold Teddy for messing up her painting? Whatever it is, she needs teacher's help in doing it. Further, there may be all kinds of situations which make the youngster fearful and clinging: meeting a dog on the way to the playground, going on a special trip, trying out a new game. Any even slightly unfamiliar situations may make the child as anxious as she was when she first came into the room.

Another way of saying the same thing, for this child, is by vague physical complaints, "I don't feel well" or "I'm tired" or "Something hurts" (usually tummy). While it is possible that something really is wrong, the teacher, after many checks and inquiries, may come to feel that the problem isn't physical at all – the child just doesn't feel very well about being in school. She may even say she wants to go home.

The teacher's role with a child like Diane is, yes, to be warmly accepting of the child's needs, but not too accepting of her complaints or clinging behavior. This is tricky because you don't want the child to feel rejected or scolded. You do want her to learn that adults believe she can do a lot on her own, that she can try out new things, stand up for her own rights with other children, even occasionally act a little like the "naughty" kids she complains about. When Diane is playing with other children, she can be encouraged, instead of "telling" teacher, to talk directly to the other children. She can be helped to find ways of disagreeing, even of being angry, without having to call on teacher all the time. She can be given the

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cuddle or hug she wants, but then encouraged to return to the group. The teacher may find that the child's mother needs to hear these things as well as the child herself. Mother may need some encouragement to let the child go into the classroom without the endless goodby, to come home looking less than perfectly neat, to go with the others on the special trip.

The teacher's continuing message to Diane might be something like, "You can do it, your're a big girl now." Very often, the child is getting exactly the opposite message at home. Maybe a new baby has arrived and the older child has concluded that it's really best for her to act like a baby too. Maybe the mother just has a hard time letting her child take the grown-up step of going off to school. Maybe the family have special worries about the possibilities of certain bad things happening or of people feeling upset or angry. Perhaps some extreme difficulty has in fact occurred in the past, like an illness or an accident, that has made the entire family fearful of what could happen next. A family atmosphere of worry or fear can make the child feel that something really terrible is going to happen, either to herself or her family, if they're not all together every second. Whatever the case, both the child and the family may do well to hear the teacher's "O.K." for Diane to act and be treated like the big girl she really is.

Sometimes much more encouragement towards independence is needed. Diane may be so insistent on staying home, for example, that her mother becomes reluctant to send her to school at all. Here it is important to try to understand the child's feelings. If a new baby has just come home from the hospital or if an accident has just happened, it may be wise to support a brief (day or two) absence for the child. But, most of the time, with no particular reason evident, the teacher will want to do all she can to support the mother in getting the child to school. Perhaps mother herself can come in for a while and stay in the classroom with the child. Eventually, the child may gain enough confidence to stay on alone, especially if she has a clear picture of mother's activities during the school morning. If long-term absences continue, the teacher should not simply forget about the child or assume that there is nothing she can do. At this point, consultation and planning with social service staff and community experts may help to assess the family's needs and reveal how Head Start can be fitted into the picture.

F. THE CHILD WHOSE SENSE OF REALITY IS SERIOUSLY IMPAIRED

There are a few children whose behavior is so strange and unusual that their severe emotional disturbance is obvious to everyone. One of the particularly striking characteristics of these children is their inability to relate well to people. Such a severely disturbed child is likely to react to people as if they were inanimate objects, bumping into them, needlessly pushing others aside, etc. In general, the behavior of these children is poorly suited to the circumstances. On the other hand, when a young child only occasionally shows such behavior following on a particularly frightening experience he is usually not thought of as being as severely disturbed as those for whom it is a usual pattern. Yet even occasional behavior of this sort is likely to mean that the child is in trouble. When a child frequently reacts to even moderate stress in these ways, it is clear that he is emotionally very ill. Such children need the help of a child guidance clinic. If these children are to profit from the Head Start experience, the teacher will need to work closely with the clinic, trying out various management techniques under their guidance. Some examples of the types of behaviors common to children who fall into this category are given below.

Many of these children alternate periods of underactivity with periods of overactivity. During periods of underactivity such children may sit for a while, completely occupied with a piece of string, a crayon or a toy. If someone interrupts this activity, the child may either show no emotion or become excessively angry. During periods of overactivity these children are likely to wander about vaguely, pace, jump up and down seemingly lost in fantasy, rock back and forth. Facial grimacing and bizarre, rhythmic hand movements are common.

Danny is an example of a child whose sense of reality became temporarily disturbed following some very frightening experiences around death. When Danny's dog died, he came to school with an angry vacant look on his face. During the morning he didn't pay much attention to what other children were doing. Finally he ran out of the classroom and began to bark and to crawl on all fours through the corridors. When adults with whom he was usually friendly tried to talk to him, he didn't seem to recognize them. When they tried to take hold of him he bit at them. Only after a long period of being held did he return to his usual self. He wanted then to control adults and order them to get him things. But he knew who he was and who they were. Two days followed in which Danny was irritable and controlling and, for different periods of time, was out of contact with those around him before this severe difficulty subsided. Shortly before this Danny had had some very frightening experiences. His beloved grandfather had died, and his father had been very seriously ill. Danny had been scared that he himself might also die. When the dog he loved died, Danny acted as if his worst

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fear had come true, that he was like the dead dog. His teacher needed another person to be with Danny for most of three days. If someone else had not been able to help out, the teacher would have had to call his mother and send him home. She didn't want to do this because his mother was not well and was herself depressed. With assistance the teacher was able to help Danny to weather the storm in school. Fortunately, both Danny and his mother were being seen at a clinic for help with Danny's fears. Collaboration between the teacher and the clinic enabled Danny to give up being so afraid.

Unlike Danny, Meg's sense of reality is very often impaired. Her typical way of relating to other children is either to ignore them or to bite and spit. As she walks around the room, she often acts as if she does not even see anyone. She bumps into others, breaking down their block structures, stepping on their paintings, etc., not because she is necessarily angry with them but as if they are not there. At other times she stands and rocks from one foot to the other seemingly lost in a world of her own. The rocking sometimes is accompanied by animal-like growling or grunting sounds. When someone approaches her, she either doesn't respond at all, or she runs away.

When Meg first came into Head Start the neighborhood worker reported that the child had been badly neglected in her own home and other living arrangements were being made. One way in which Meg reacted to the neglect was to ignore other people. In the course of the school year, however, with the teacher's help, she did make some progress. One of the most useful things the teacher did for Meg was to hold her firmly when she began either to bite or spit. This was useful in part because it prevented other children from regarding Meg as an enemy.

Some children like Meg often spend a lot of time making peculiar movements of the face, especially of the mouth. Sometimes they do this in front of a mirror, trying out a number of different grimaces. Such behavior can be very frightening to the other children and should not be disregarded by the teacher.

If the teacher can encourage others to play with such a child and to share their activities and play materials, this can be very helpful, but usually the teacher will need to stay close by and direct the sharing. In one instance, the teacher was able to get a grimacing child accepted by others for a short time, at least, by suggesting to two little girls who were playing house that Sarah could be a very good cook. Since even temporary acceptance is very reassuring to Sarah the teacher would do well to look for further opportunities to help Sarah feel useful and wanted.

The *autistic* child also falls into this general category. These children often seem even more out of touch with

reality, even more withdrawn and unable to communicate with other people than the Danny's and the Megs. They therefore present a very special problem in the classroom. They tend neither to relate to people nor to react to play material. Their general lack of responsiveness to external stimulation sometimes raises questions as to whether vision and hearing are seriously impaired. But usually this is not the case. These children may have multiple problems contributing to their severe isolation. Such children may be retarded (they certainly are retarded in language development); some may have suffered from severe emotional deprivation; and some may have some neurological impairment. It is important to remember that all children who do not speak are not so severely disturbed. Some are just afraid to talk. Such a child is readily seen to be different from the severely impaired child by his ability to use play material and to relate through it to other children.

Sometimes when an autistic child is in a group he will occupy himself with one simple activity, repeating it over and over again, like spinning a cover, watching sand drip through his fingers, or whirling his own body. Sometimes he is afraid of noise and is very sensitive to the normal noise level of the class. When the noise gets too much for him he may cry or scream and hold his hands over his ears.

A general characteristic of the autistic child is his tendency not to look at other people's faces. If he does make eye contact, he usually does not sustain it.

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Sometimes such children have *echolalic speech*; that is, they will repeat exactly what the mother or teacher may say to them but not be able to answer. They usually have not learned the pronoun "I," and in the small amount of talking they do, do not seem to be able to tell the difference between themselves and someone else. Sometimes they indicate by their actions that they understand much more than they communicate in speech. At other times they seem blank, unaware of what is being said to them.

The teacher can only tend to the needs of the autistic child if she has enough adult assistance. He may need his mother in the classroom with him at the beginning and will probably need an adult who can spend time with him individually through the year. A shortened school day at least for the first part of the year will probably be necessary, and getting comfortable being near other children, and sometimes engaging in games like "Ring around the Rosy" with the teacher helping him, may be a reasonable goal.

In so far as she is able, the teacher can encourage the autistic child to speak by naming the things she gives him to play with and things she gives him to eat, but she should know that speech from him to her will be slow in coming. Her pleasure at any of his attempts will be his best help.

Since all of the children we have described in this section typically need a great deal of one-to-one attention from the Head Start teacher, it is important to limit sharply the number of such children admitted to any one classroom. Yet, if there are enough teacher aides available and if most of the other members of the class do not also have severe problems, it may be highly desirable to bring the severely disturbed child into the Head Start program. Such children can sometimes profit from the opportunity to learn that it is safe to relate to other children and adults.

G. THE NEGLECTED CHILD

The term *neglected child* refers to the child whose physical needs have been grossly ignored by his adult caretakers. Characteristically these children are seriously undernourished and little or no attention has been paid to their day-to-day needs. Minor, and often even major, illnesses have been allowed to go untreated. Lucy, for example, suffers from frequent colds. But despite a runny nose, teary eyes, a hacking cough and a generally feverish appearance, she is sent to school. Lucy is clearly undernourished and at snack time is likely to try to cram an entire platter of crackers into her mouth at once. The clothing of a neglected child like Lucy is usually ill-fitting, dirty and torn. The smell of urine is strong when she arrives in the morning. Her hair is uncombed and dirty. If cut short, the hair looks chopped off. If left long, it is a matted, stringy mess. Rashes, obviously itchy, cover the face, arms, and legs, and Lucy's constant scratching increases the likelihood of further infections. Lucy's plight is very serious. Neither the neighborhood worker nor the teacher has been able to interest the mother in Lucy's general situation, though together they did succeed in arousing some concern about one of the child's illnesses, diseased tonsils.

In Lucy's case, the mother's neglect seems to be based on rejection, in part unconscious, in part conscious. She did not want Lucy in the first place and has never been able to express any warmth toward the child. In this attitude she differs from Daniel's mother although the latter also neglects her child. Daniel's mother does not actively dislike Daniel; it is just that she cannot be bothered with the care of any child. Having never really grown up, she yearns to be taken care of by others, rather than to be a caretaker herself. On the other hand, the basis for the neglect in Emily's case is of a still different order. Emily's mother has a long history of severe depression and is unable to mobilize her energies sufficiently to meet even the simplest needs of the family. To get the children dressed and fed in the morning is beyond her. They must fend for themselves. All these mothers need professional help. So do the children.

As in the case of the physically abused child, the neglected child may need both medical attention and temporary or even permanent foster care. How can this be accomplished? Can the neighborhood worker or the teacher or both together bring such a child to the attention of the appropriate authorities if the parents are unable to remedy the situation by themselves? Most states now have laws which protect the reporting person from legal action for slander or libel. All states protect reporting doctors; others extend the protection to school officials and social workers, though not necessarily to individual teachers.

H. THE BATTERED CHILD

The term *battered child* refers to the child who has suffered severe physical abuse. The term is well chosen since the injuries to the child typically are quite evident. The injuries seen most frequently are painful burns in areas where one would not expect the child to burn himself, broken bones and multiple bruises. In some cases, the injuries are accidental, but in others an angry parent or parent-substitute has inflicted some physical punishment when the child's behavior at home became extremely annoying. Excessive crying or excessive stubbornness can, of course, be very irritating to an adult, especially if the

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adult has been ill or is in general having a hard time meeting the needs of the family. In such circumstances most adults will resort to some form of punishment. But only in rare cases does the punishment become violent enough to constitute battering.

In cases of intentional battering evidence of previous assaults on the child can usually be found. Anne, for example, came to school one day with multiple bruises on her face and arms. On examining the child, the teacher observed a number of patches of scar tissue left over from previous burns. Anne's general condition had been noticeably poor for weeks, suggesting that she was not being well cared for. Unlike Tom, who came into the classroom boasting of how he had broken his arm over the weekend, Anne hangs back when questioned about her bruises. She is a joyless child. Anne's situation is serious. Her first need is for medical attention. But she also needs to be protected against further assaults. If Anne has not already received medical attention, it is appropriate for the teacher to communicate with the mother and urge her to take the child to a doctor. If the mother is unable or unwilling to seek medical help for the child, or if there is evidence of continued battering, the teacher should report the situation to the appropriate Head Start administrative officer.

Laws have now been passed in all states making it mandatory for doctors to report battered child cases to an appropriate agency, the police, the Society for the Prevention of Cruelty to Children or the Department of Public Welfare. Many states require other persons in authority to make similar reports.

Follow-up by a member of the clinical team is advisable in these cases. Where only one child in the family is the object of parental assault, it is important to study both the child's behavior in the home and the parent's. Is there something about this child which the parent cannot tolerate? What are the chances that the parent will be able to stop assaulting the child? Should foster placement be recommended? These are questions to be pursued by the clinical team rather than by the teacher.

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VI. Medical Information About Childhood Handicaps and Health Impairments

What follows in this section is medical information about some of the physical handicaps you may encounter, accompanied by suggestions about how to manage medical aspects of the handicap in the classroom. This section does not include *all* of the handicapping conditions you may encounter; it is intended to include representative examples. You will find suggestions about classroom management of educational and psychological aspects of physical handicaps in Chapters III, IV, and V.

Some medical conditions such as asthma are not strictly speaking handicapping conditions covered by the law. However, children with *chronic* asthma may present problems in the classroom and may thus require special services; therefore information about these and other *health impairing* conditions is included. The inclusion of a condition in this manual does not necessarily mean that it is to be counted in compliance with the 10% handicapped requirement. Nor does the absence of a condition from this manual signify that it is not a valid handicap. Decisions about whether an individual child is handicapped under the Congressional mandate are to be made by professionals using OCD guidelines.

You will, of course, *not* encounter in your classroom most of the handicapping conditions described in this section, some of which, like *hemophilia*, are relatively rare. If you do have a child with a physical handicap in your class, reading that section will provide you with useful information.

It is important to remember that not all medical problems are equally handicapping for the child. Some, like asthma, may involve occasions when breathing is difficult; yet for long periods between attacks the child may be perfectly normal. Other problems, such as heart disease and deafness, affect the child's condition at all times. The same problem can also vary in severity from child to child. One child with cerebral palsy may be restricted to a wheel chair; another may walk and grasp clumsily, but require no special equipment at all.

Children With Multiple Handicaps

Some children may have more than one handicap. A child with cerebral palsy may have a severe vision problem or may be slow in mental development. A mentally retarded child may also be overaggressive in the classroom or quite passive and lacking in initiative. Children who are subject to seizures or who have chronic asthma may, understandably, be frightened of separating from their mothers and remaining in the classroom. It is a good idea to keep in mind generally that children with physical handicaps may develop emotional reactions to their handicap: some may be frightened at separating from their home and parents, some may feel ashamed of their differences from other children, some may feel more helpless and impaired than they actually are, while others may not recognize the limitations their handicap imposes, and may get themselves into dangerous situations. If you have a child with multiple handicaps, you will need to refer to more than one section of the manual. In that case, the table of contents and the index should assist you. A preliminary reading of the entire manual will also help you to locate information you might require at a later date.

The books and pamphlets listed in Appendix 2 offer more detailed information. Additional, often essential, information can be obtained from the referring source. Parents too are a most important source of valuable information about an individual child. They can and will tell you what you need to know about any special equipment such as braces and hearing aids, and can also alert you to any potential crises that may arise and tell you how to deal with them. For example they can tell you what to do if a child gets an asthmatic attack in the classroom.

A. CHRONIC ASTHMA

Most of us are related to, or acquainted with, or have heard of, someone who is known to have asthma. In a general way we may have some idea of what an asthma attack is like, but this vague knowledge is poor preparation for the actual experience of seeing a small child in the throes of a severe onslaught. The child may have to struggle and gasp for every breath, may exhibit fear to the point of panic and may give the appearance of a person about to drown or smother. Since asthma is widespread at every age level, an asthmatic child is likely to appear on the roll of

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any Head Start classroom, and teachers should be aware of some basic facts about the condition and the problems that may be encountered.

Asthma, like many other medical conditions, varies in severity from child to child. *Chronic* asthma, with its frequent and severe attacks, alters the child's ability to participate in the program. Children with chronic asthma are more likely to develop respiratory infections and be absent from school more often than other children. The staff may require instruction from a physician or parent on the procedure to follow if a child has an asthmatic attack.

Asthma is an allergic condition of the lungs. Some authorities contend that asthma has a genetic or psychological component (or both), but such explanations are in dispute. The characteristic symptoms show themselves in recurrent attacks of labored breathing, accompanied by *wheezing* and *coughing*. The symptoms result from blockage of the small branching air tubes (bronchioles) in the lungs. This blockage impedes the air flow. Excess production of mucus is an accompanying symptom. Since reduction of the air flow in an attack interferes with the normal cleaning mechanisms of the lungs, multiplication of bacteria is favored, and infection becomes a common complication. When the infection occurs in the air passages, we call it bronchitis or bronchiolitis. If the microscopic air sacs (alveoli) at the ends of the bronchioles are infected, the resulting disease is pneumonia.

The first step in treating asthma is to prevent the attacks is to discover what substances (allergens) the child is allergic to. The investigation is carried on systematically by eliminating one suspect substance after another. When the child's special sensitivities are isolated, an effort is made to remove all the offending substances from his environment—whether house dust, pets, upholstery stuffing of animal hair or feathers or certain foods. The list can be long, and the restrictions may complicate the child's entrance into a different environment, as in the Head Start classroom. These are matters that must be discussed, of course, with the child's parents and their doctor.

If the asthmatic child has been under the care of a physician, he may be receiving medication regularly or there may be a prescribed procedure to follow in the case of an attack. One medicine often is given to block the effects of an inhaled allergen on the air passageways. Other medications relieve muscle spasms in the air tubes, and cough medicines help to loosen excess mucus. There also are injections to desensitize the asthmatic. Here again consultation with the parents and doctor is in order so that the teacher can know what to do in the case of an attack. Many parents of asthmatic children have had to learn a great deal about the condition and can give reliable information on how to deal with an attack. A plan for such a contingency should be worked out at the time an asthmatic child is enrolled in Head Start.

In general, asthmatic children should be encouraged to join in the normal play of the class, indoors or on the playground. Though they may tire easily, there is no medical reason to restrict their activity.

B. BLEEDING DISORDERS

As medical problems go, bleeding disorders are not very common, but now and then a child with one of the three major types can be expected to appear in a Head Start classroom.

Prolonged, excessive or unexpected bleeding out of proportion to the seeming severity of an injury is the characteristic common to these disorders. After a minor fall a joint swells with blood. Brushing the teeth causes the gums to bleed. The socket of a pulled tooth oozes blood hours later. Large bruises discolor the skin after even a mild jump. The three major groups of blood disorders are:

1. The *hemophilias*, which are abnormality of the amounts or kinds of blood proteins responsible for blood clotting.
2. A reduction in the number of blood cells (platelets) which help to stop bleeding when a blood vessel is injured.
3. *von Willebrand's Disease*, which involves abnormalities of both platelets and clotting proteins.

The hemophilias are the bleeding disorders most likely to be seen by a Head Start teacher. In some types of hemophilia the mother passes the disorder to her male offspring only. The world knows this hemophilia as the royal disease, transmitted by Queen Victoria of England to a number of the crown heads of Europe before World War I. There are also other hemophilias, however, that develop spontaneously.

Platelets, the blood cells which help to stop bleeding, may be reduced in number because of a reaction to a medicine or because of an infection. More often, the cause of reduced platelets is unknown, and the resulting illness is called "*idiopathic thrombocytopenic purpura*." This is the medical term for a condition of unknown origin characterized by easy bruising due to a deficiency of platelets.

In recent years there has been major progress in the treatment of all the bleeding disorders with transfusions, injection of proteins, use of cortisone and other methods, and there is no longer need for the excessive precautions once taken with affected children. Overprotection may

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spare a child some bleeding episodes and a few trips to the doctor, but the psychological price paid may outweigh the benefits. The Head Start teacher who has a child with hemophilia in her classroom should not be afraid that he is in danger of bleeding to death at the slightest injury.

The principles of first aid for a bleeder are simple. Treat any cut or skin scrape as you would for a normal child. The best way to stop bleeding is to apply pressure directly on the wound with a clean gauze or other dressing. Call the doctor only if you cannot stop the bleeding in what seems to be a reasonable length of time.

If a child with hemophilia injures a joint, an ankle, elbow or knee, put him in a position of rest. Wrap the joint to immobilize it. The elbow can be immobilized in a sling. Fill a plastic bag with ice cubes, wrap it in a towel and apply it to the injured joint. Then call the child's parents or physician.

One word of caution should be emphasized. The one location where bleeding can be immediately dangerous is in the neck or throat. A large collection of blood there can obstruct the airways. In this fortunately rare event the child will complain of pain or swelling and show obvious signs of difficulty in breathing. This is an emergency, and a doctor should see the child at once.

After a child with hemophilia has had medical treatment for an injured joint he may be on crutches or have an arm in a sling for a few days. At these times he will need your support and often your reminders that he should not try to run without his crutches.

Certain common drugs such as aspirin, phenergan (an anti-histamine which is widely used in cough medicines), glyceryl guaiacolate (a common expectorant in cough medicines) and tranquilizers can aggravate bleeding tendencies. Accordingly, it is unwise to give a child with a bleeding disorder any medication without a prescription from the physician. In general, it is unwise for any medicine, even an aspirin, to be administered to any child except by knowledgeable personnel. Medicine should never be administered to a child with a specific medical condition without a written order from a physician.

The development of personality can take several courses in a hemophiliac child. Some may be able to accept the fact of the disease and cope with the limitations. Others may become so fearful of injury that they sink into a passive existence. Still others may turn into hemophiliac daredevils, seeming to go out of their way to expose themselves to danger. Whatever course the personality is taking, a pattern will already be apparent by the time the child reaches school. The teacher will not find it easy to keep the child on a mid-course between overprotection and permissiveness, but she will profit from consultation with the parents. As in the case of other kinds of handicaps, the teacher will find out that the parents have had to acquire sound ideas about the child's condition and the requirements for safety.

C. CEREBRAL PALSY

Cerebral palsy is a disorder of movement (muscle action) or posture caused by a nonprogressing disorder of the brain. The disorder of muscle action is a permanent disability but can change over time in quality and intensity. While intelligence may be affected in cerebral palsy, often it is normal. Until a thorough assessment has been made, the Head Start teacher should never assume that the intelligence of a child with cerebral palsy in her classroom is defective or that she will have to cope with learning problems.

There are many known causes of the kind of brain damage that leads to cerebral palsy; excessive jaundice in the newborn, deprivation of oxygen at birth, head injury, infections of the brain and spinal cord and lead poisoning are among them. The brain damage cannot be corrected, but this is not to say that improvement in the spastic's performance is impossible.

Cerebral palsy ranges in severity from barely noticeable clumsiness (ataxia) to the obvious crippling that requires braces and wheel chair. At birth a baby with cerebral palsy may have a weak or paralyzed arm or leg. Later on the muscles of the affected limb may become tense (spastic), bending the arm at the elbow or pulling the thigh up toward the abdomen with the lower leg flexed and the foot extended downward. Some children with cerebral palsy have movements they cannot control (athetosis). Grimacing and a peculiar posture are frequently seen. The muscles used in talking may be impaired, resulting in indistinct, halting speech.

A physical complication of constant muscle spasm is shortening (contracture) of the tendons which are the sinewy bands attaching muscles to bones near a joint. For example, the heel cord (Achilles' Tendon) may be shortened, because of constant spasm of the calf muscles and downward positioning of the foot. The foot may then not be able to move into any other position. Contractures of tendons seriously interfere with function. Even with braces, a child with a foot locked in a downward position will not be able to walk.

Minimizing contractures is a major objective of medical treatment. This goal is accomplished by moving the joints through a full range of their motion, thus stretching the tendons and keeping them supple. These exercises are taught by a physical therapist to the parent who carries

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them out each day. Other exercises which actively involve the child are designed to strengthen weakened muscles. Surgery may be needed to lengthen contracted tendons and to shift spastic muscles to new locations. Braces are used to add needed support to weakened legs and thereby permit walking.

The Head Start teacher of a child with cerebral palsy will need to know how to remove and put on braces and how to adjust them. She can get this instruction from the child's parents, and she will also find the father and mother a good source of information about the child's abilities as well as the child's problems. A physical therapist may instruct the teacher in exercises that can be performed in the classroom. The effort required to help the child with severe cerebral palsy use his body to its maximum effectiveness is often rewarded by developmental progress.

D. CLEFT PALATE

Children with cleft lip (harelip) and cleft palate will arrive in Head Start after a long history of disability and traumatic experiences that will have influenced their personalities in different ways. Cleft lip is a frequent general anomaly that develops in the baby before birth. It can be a small indentation of the lip or it can be a more serious defect, with a fissure extending to the nostril, giving to the face a characteristic appearance. A cleft palate can also range from mild to severe and can occur with or without cleft lip. The infant with cleft lip alone usually presents no feeding problems. Surgical repair can be done early in the child's life, usually within the first two months. The child with cleft palate, on the other hand, presents a more complicated picture. During early infancy he can have difficulty sucking, and may have to be fed with a dropper. But very rapidly he masters the situation. At a remarkably young age he insists on holding his bottle and doing his own feedings. Usually by eighteen months surgical repair can be carried out, but very often several operations will be necessary in order to obtain full correction. Imagine how traumatic it might be for a child this age to go through all those procedures. This certainly makes an impact on future behavior. Babies with cleft palates tend also to accumulate fluid in the ear and to develop repeated ear infections. Not only is it a very painful experience, but it can also be the cause of impaired hearing, an additional factor that contributes to communication difficulties. Speech development is usually delayed. A child with cleft palate will often have articulation errors and a nasal quality to his voice which will make him very difficult to understand. One can observe the hurt and the relative social isolation of a child

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who talks but is often not understood and who not only looks, but sounds different from other children.

E. CYSTIC FIBROSIS

Although cystic fibrosis is one of the most common of the serious chronic diseases of childhood, for some unknown reason it occurs less frequently in Black children than in Caucasian children. Cystic fibrosis is a disorder characterized by abnormal production of mucus in several organs. The cause is not known, but it is believed that children born with the disease lack some key substance or substances essential to the normal functioning of a number of organs.

The lining membranes of organs secrete mucus which in cystic fibrosis is much thicker, more viscous than normal mucus, almost like glue in fact. This abnormally thick mucus clogs the bronchial passages, impeding breathing and predisposing the child to pneumonia. It also blocks ducts that deliver enzymes to the pancreas and thus interferes with normal processes in the small intestine. The child has difficulty digesting his food. Cystic fibrosis is not contagious.

Cystic fibrosis affects the functioning of the lungs, sweat glands and digestive system. Whereas normal mucus is a lubricant in the lungs enabling a person to clear the lungs by coughing up accumulations of mucus, the thick mucus of cystic fibrosis clings and clogs, becoming a fertile medium for the growth of bacteria.

The child with cystic fibrosis is likely to do a great deal of coughing in the classroom. The teacher should make a point of accepting his cough in a matter-of-fact way, and the other children will follow her lead. The teacher should encourage him to take part in physical games since the exertion will tend to make him bring up mucus. Participating in games will have a beneficial effect because often the child with cystic fibrosis lacks the stamina to compete on equal terms. He needs the teacher's encouragement and also her watchful eye to see when he is pushing himself to the point of exhaustion.

The involvement of the lungs in cystic fibrosis sometimes arouses fear of contagion. On the contrary, the child with cystic fibrosis is not a spreader of contagion but an easy victim. To him any pulmonary contagion is a very real menace, and the appearance of flu in the school is a signal to keep him at home. Nevertheless, the cystic fibrosis child often has a better-than-average attendance record.

Obstruction of the pancreatic ducts in cystic fibrosis leads to difficulty in the digestion of fats, carbohydrates and proteins, since digestive juices secreted in the pancreas do not reach the small intestine. As a result the child with cystic fibrosis may eat not just more but a *great deal* more than normal children. He may take capsules of pancreatic enzymes to aid digestion. With or without these capsules the child with cystic fibrosis may have increased bowel movements. If the teacher is aware of this possibility she can treat the occurrence as a matter of course and avoid problems.

Excessive sweating is another characteristic of cystic fibrosis. From infancy on, the skin of a child with this disorder has a salty taste. To compensate for salt losses in sweating, the child may layer his food with salt and in hot weather may need to take salt tablets as a supplement — but only on prescription from his doctor, of course.

A child with cystic fibrosis needs acceptance by his peers. Because his lack of stamina restricts his playground activities, he sometimes feels left out. At home his condition has made him the object of special attention since babyhood, and he may have difficulty adjusting to group situations in which he must share the spotlight. The teacher's assistance in making that adjustment easier is most important.

F. DIABETES

Diabetes is a disease occurring at all ages which affects some 3 million people in the United States. Of these, about 4% have onset in childhood. Its exact cause and prevention are not yet known. Many diabetic children have a family history of diabetes. Sometimes diabetes in an older family member develops after the onset in the child. It is generally thought that a hereditary contribution from both parents is necessary to produce an affected child.

This is what happens in diabetes. Normally, sugar moves smoothly from the blood into fat and muscle cells as needed for energy and the level of sugar in the blood remains fairly constant. As the cells need more sugar, *insulin*, a hormone made in the pancreas, is released. Insulin is needed to help sugar pass from blood in cells. As the cells' fuel needs are met, insulin output is reduced.

The problem in diabetes is a lack of adequate insulin to permit passage of sugar into hungry cells. If sugar cannot get into the cells more is passed into the bloodstream in an effort to overcome the blockage. The blood sugar level rises and eventually the kidneys pass the excess sugar into the urine. The sugar spilled in the urine draws along with it a great deal of water, resulting in frequent urination and excessive thirst. (One common symptom of diabetes is bed wetting in an otherwise dry child.) The starvation of body cells deprived of sugar stimulates the breakdown of body fat into building blocks known as fatty acids which, in the absence of sugar, are used for energy. The mobilization of

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fat leads to weight loss and increased appetite, both characteristic signs of diabetes. In the process of using the fatty acids, the blood becomes acid, leading to quickened deep breathing. The fatty acids are processed into *acetone* which appears in the urine along with the sugar. Without treatment, the course of childhood diabetes is progressively downhill with weight loss, dehydration, coma, and death.

This group of symptoms and signs (syndrome) of untreated diabetes is known as *diabetic keto-acidosis*. It is usually the presenting picture in new diabetics. Diabetics who are under treatment can experience the syndrome when their diabetes is out of control. Most newly detected children with diabetes are hospitalized for treatment of their first episode of keto-acidosis.

Treatment of diabetes consists of increasing blood insulin by daily injections in order to help the sugar get into cells, well balanced diet without concentrated sugars, normal amounts of exercise, and education of parents and child about management of the disorder. Pills to lower blood sugar have no place in treating juvenile diabetics. The family and the patient must become familiar with the testing of urine for sugar and acetone, the administration of insulin by hypodermic needle, and how to adjust insulin dosage to keep the urine spillage of sugar and the blood sugar level within acceptable ranges. They learn how infection, exercise, and diet can change the insulin requirement. As the child grows older he must assume increasing responsibility for his own care. For some children, attendance at a summer camp for diabetic children may aid in this maturation.

The diabetic child can do everything the normal child does. There should be no restrictions of activity. With regard to food, with the exception of sweets, the diabetic child in most cases should be able to eat the same foods as the other children. It is a good practice, however, to ask the child's parent or physician what special features there may be in the child's diet.

Sometimes too much insulin can be administered and results in the lowering of blood sugar below normal, also called hypoglycemia. Hypoglycemia causes symptoms such as fussiness, headache, hunger, drowsiness and inattention, sweating, and coolness of the skin. Each child shows symptoms characteristic for himself. Ask the parent to describe her child's pattern so that you will know what to look for. If a teacher notices these symptoms in a diabetic child, the most immediate treatment is to give sugar-containing foods like orange juice, or a piece of candy followed by a glass of milk and several cookies or graham crackers. If after five minutes the child doesn't improve, contact the doctor or follow whatever plan has been made for such a situation. If the child is not awake, give nothing by mouth, lest he choke. Severe and prolonged depression of the blood sugar causes unconsciousness and coma. An injection of glucagon, a hormone which raises blood sugar, or a dose of sugar by veins will bring the blood sugar back to normal.

The hypoglycemia associated with administered insulin is known as an *insulin reaction* or *insulin shock*. If it occurs frequently it may be necessary to adjust his insulin and/or diet.

If a diabetic child develops an illness, such as a cold, treat him as you would any other child. The teacher may want to learn the easy steps for checking the urine for sugar and acetone, as this may provide useful information for the parent or physician.

With rare exceptions, once children develop diabetes they have it permanently. The overall outlook for survival and for a comfortable life is problematic. The first generation of treated childhood diabetics is only now in the adult age group. Many adults with childhood onset of diabetes which has persisted for as long as 15 to 20 years have developed complications which include kidney disease, high blood pressure, arteriosclerosis, changes in the blood vessels of the retina, and cataracts in the lenses of the eyes (both eye complications interfering with vision).

G. EPILEPSY

An estimated 1,500,000 Americans have epilepsy. While this figure may not indicate a high probability of encountering a child with epilepsy in any given Head Start classroom, it suggests at least that the possibility does exist and that Head Start staff should know how to deal with an epileptic seizure.

The first important fact to know about epilepsy is that it has nothing whatever to do with insanity. Most epileptics are in other respects normal and healthy, of average or better-than-average intelligence. Many great musicians, writers and thinkers have had epilepsy, but the handicap did not prevent them from leading richly productive lives. Persons with epilipsy differ from the rest of us mainly in their tendency to have *seizures*, which range in severity from momentary spells of clouded consciousness to the startling convulsive episodes known as *grand mal*. It is grand mal, in which the person falls unconscious, froths at the mouth and may turn blue, that aroused superstitious dread in ancient times and even today may frighten onlookers, quite unnecessarily.

In most cases the cause of epilepsy is never known, except in a general way. It is assumed usually that a brain injury is to blame. Such an injury may occur in the womb or at birth, it may come from a bad fall or severe blow or it

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may be a result of certain infectious diseases, such as meningitis, to mention one. In any event, it is believed that a seizure follows when a group of the affected brain cells for some unknown reason becomes overactive. Only a particular region of the brain may be involved, or the overactivity may start in one region and spread to others or over the entire brain. The severity of the seizure may depend on the location or on the extent of the regions affected.

It is not likely that a Head Start teacher will be the one to discover epilepsy in a child given to *grand mal* seizures, but it is conceivable that a teacher might be the first to notice something amiss in a child whose epilepsy so far has been manifested only in *petit mal* or *psychomotor seizure*. The former is a simple "absence" without any of the frightening convulsions characteristic of *grand mal*. While the person in *petit mal* seizure does lose consciousness for a few seconds, he does not fall to the ground or thresh about. To the onlooker, the only visible sign may be a rhythmic fluttering of the eyelids. On regaining full consciousness, the person in *petit mal* usually resumes doing whatever he was doing before the attack. The episode is so fleeting and so unnoticeable to others that an unaware or unobservant teacher could mistake it for daydreaming. In *psychomotor seizure* the epileptic tends to repeat over and over some complex physical movement — chewing or swallowing or fingering some object — or he wanders aimlessly about the room. These physical actions are performed in a vacant manner suggestive of sleepwalking. The attack lasts a minute or so and is followed by a period of confusion lasting another minute or so. The person hears no call or command during the attack and has no memory of the episode. Here again the circumstances are such that an unbriefed or unobservant teacher could mistake the attack for classroom misbehavior. If a teacher does observe symptoms suggesting *petit mal* or psychomotor seizure but has no information to link the child with epilepsy, she should, of course, report the incident to the child's parents and to the appropriate specialist in the Head Start program.

If a child goes into *grand mal* in the classroom, there will be no mistaking the attack for daydreaming or misbehavior. The child may have brief warning of the impending seizure but may not. He will lose consciousness and fall, toppling off a chair if seated. He will tighten all his muscles violently, this muscular rigidity then usually giving way to convulsive jerking of the arms and legs. The eyes will roll up and froth appears around the mouth. He may turn very pale, even blue. He may wet or soil himself. There is a possibility that he will bite his tongue or the inside of his cheek.

The grand mal seizure usually lasts only a few minutes. Afterward the child will appear to be confused and may complain of headache. He is likely to seem exhausted and may fall into deep sleep. He will have no memory of the attack, but in a general way he may give the appearance of being embarrassed and deeply disturbed.

Although educated persons long since discarded the ancient superstitions about "fits" and "spells", the first encounter with epileptic seizure does seem to affect most lay persons with a feeling of helplessness, at least. A knowledge of several simple facts will ease that feeling and enable the onlooker to be useful:

1. The seizure will not last long.
2. The person in seizure is not suffering any pain.
3. Though unconscious and frothing at the mouth, the person is not going to die and is unlikely to suffer any serious injury.
4. The onlooker is not going to be hurt unless, in a mistaken notion of how to be helpful, he puts his finger in the person's mouth and is bitten.

The teacher should be aware also that many epileptics experience the warning called *aura* preceding an attack. A child may not be able to find words to describe the sensations, but the aura apparently includes peculiar feelings in the stomach region, spots before the eyes, odd sensations of taste or smell, flashing memories of old events, unusual tensions and anxiety. In the classroom the aura may give the teacher time to carry the child to a safe place to lie down during the attack.

Since the epileptic in grand mal is almost sure to fall, the first step is to try to prevent him from hitting a sharp edge or corner and thereby suffering injury. The safest place for an epileptic in grand mal is on a mattress, soft rug, or pile of blankets or clothing on the floor.

Loosen tight clothing, especially at the neck. Wipe away any froth or saliva around the mouth and nose to aid breathing. Old first aid manuals recommend insertion of a hard object or your finger between the teeth to keep the epileptic from biting his tongue, *but don't do it*. The violent muscle contractions could damage the child's teeth against a hard object, and by the same token his teeth could seriously lacerate your own finger. Don't try to hold the person down. Restraint will only cause more violent reaction and lead possibly to wrenched or strained muscles. If the child is in a safe place, and preferably on a soft surface, leave him alone until he recovers from the attack. Placing him on his stomach, with his head turned toward the side might be helpful.

The teacher should try to observe closely and to remember what happens in the early stages of the attack.

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This information will be useful to the specialist in charge of the case.

As the foregoing descriptions suggest, epileptic seizures ordinarily do not constitute emergencies in the medical sense. There is, however, a rare exception called *status epilepticus* that calls for hospitalization at once. This is a series of convulsions, one after another, each occurring before the victim has fully recovered from the previous convulsion. The duration and severity of the symptoms will be unmistakable.

In dealing with a child after a seizure, your attitude and manner will be important. The child is likely to be confused and embarrassed, and the best comfort you can give is to assure him quietly that all is well. You should do your best to remain calm and to give an appearance of confidence, for the benefit of the other children as well as the one who has had the seizure. Your main wish should be to avoid alarming the children. Assure them that the episode was not serious and that the child will soon be all right. If this is the first attack for the child in your classroom, you should have the parents notified as quickly as possible. They may wish to call a doctor.

Epilepsy is treated with anticonvulsant drugs, and the schedules for this medication are fairly rigorous. The teacher who has an epileptic child under her care should make doubly sure whether any dosage or dosages are to be administered to the child in school hours. Since the doctor's prescriptions may vary with changes in the child's condition, it would be wise to double check from time to time to make sure that you understand what is expected in respect to medication.

A child with epilepsy should take a full part in the normal life of the classroom. The possibility of a seizure should not be an occasion to alter the curriculum for the child or to restrain his activities. Subject to contrary instructions from his physician, the child should be allowed to participate in most playground sports and games. When a child is subject to seizures, crossing busy streets and such activities as bicycle riding and swimming perhaps do pose special risks, but common sense will provide sufficient precautions to avoid accident. The teacher should make an effort to find out from the child's parents or doctor how often seizures can be expected to occur.

The effects of the seizures on a child's classmates will depend on the attitude and influence of the teacher. As in dealing with other handicaps, the teacher's care of a convulsing child can provide a practical and vivid lesson in first aid and human relations from which the other children may benefit.

Children with seizure disorders are prone to certain behavior problems. Their attention spans may be short, and they may be given to some destructiveness. This sort of behavior will be more noticeable in younger children. The anticonvulsant medicines prescribed for children with seizure disorders may depress the mental function, especially if the dosage is heavy, and the teacher should be aware of this condition. The children may develop severe anxieties about their condition, and these anxieties may be accentuated if parents make an elaborate show of concealing the facts. For this reason, the companionship and respect of their peers are important to children with epilepsy, and Head Start therefore has much to offer them beyond a foundation for further schooling.

H. HEARING IMPAIRMENT

The child with a severe hearing impairment is handicapped in many ways. Speech and language acquisition are hindered although with special rehabilitation they can improve. Emotional and behavioral changes arise from the frustration and loneliness of living in a "deaf" world. Regular educational programs depend primarily on verbal communication so the child with a severe hearing loss requires special educational efforts. Many deaf children have normal IQ's and are bright children. Their ability to learn is high and this potential capability must be understood if each and every deaf child is to achieve a more meaningful life.

Hearing tests can be done at any age including birth. By six to nine months of age reliable tests for each ear can usually be obtained. By three years of age the kind of hearing loss can be determined. There are two basic kinds of hearing loss: conductive (due to the ear canal or middle ear) or sensorineural (due to inner ear or auditory nerve). In conductive hearing losses, a blocking or reduction of sound reaching the inner ear occurs. Conductive hearing losses may be due to an absent ear canal (an obvious deformity), fluid in the middle ear (which can be detected on an ear examination with an otoscope), or to misshapen or malpositioned bones in the middle ear (which can be detected by an ear operation). Fluid in the middle ear, so very common in young children, usually gives a milder hearing loss manifested by "not wanting to hear," the TV tuned loudly, inattentiveness at school, or minor speech problems. Only rarely does middle ear fluid give a severe loss but if it does, surgical correction is easily achieved. The middle ear bone deformities are often associated with misshapen or prominent outer ears, cleft lip and palate, or other deformities of the head and neck.

In sensorineural hearing losses, the most common reason for a severe hearing impairment, the auditory nerve

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transmitting sound impulses to the brain, is defective. These losses may be hereditary or acquired. Hereditary losses may occur alone or may be associated with other problems such as white patches of hair in the midforehead area, visual changes, or thyroid disease. Acquired losses may occur during pregnancy (from German measles or other viruses), at the time of delivery (from severe yellow jaundice, prematurity, or not enough oxygen), or at any time after birth (from mumps or other viruses, head trauma, or meningitis). Only some of the time can a precise cause be determined; more often the reason goes undetected.

Treatment for children with severe sensorineural losses must be flexible so as to provide appropriate stimuli for each child to respond. Hearing aids can be started by nine months of age — often the earlier the hearing aid, the better the speech patterns. Speech therapy may also utilize lip reading, sign language, finger spelling, and tactile or visual stimuli. Parents are integrated into these programs so they can reinforce educational programs at home.

Treatment for children with severe conductive losses is surgical. Fluid can be corrected at any age; middle ear reconstruction is usually performed between five and ten years of age. Prior to surgery, a hearing aid and other educational techniques enumerated above should be used to provide adequate hearing.

One must be patient and understanding with deaf children. Although they cannot speak well, they are not dumb. Instead, they are often bright, sensitive, and inquisitive children. Talk slowly and loudly, making certain that they can see your lips while you talk. Seek guidance not only from pediatricians, ear specialists, audiologists and speech therapists but also from psychiatrists, social workers and psychologists.

I. HEART DISEASE

Another handicapping condition that teachers in Head Start are likely to meet is the child with heart disease. The description of each one of the conditions that can produce cardiac disability is beyond the scope of this work, but a few general words are in order. The heart is a four-chambered pump with four valves controlling the flow into each chamber. Its function is to pump blood through the body. The heart can suffer damage in various stages of development of the individual. Before birth, during pregnancy, the development of the heart can suffer alterations that will affect its function. For instance, abnormal communications can persist between the chambers or the valves can develop in such a way that complete closing or opening is prevented. The heart can also be affected after birth. The most common occurrence will be rheumatic fever. In this disease the valves are affected after an infection with a specific micro-organism (streptococcus) which occurs in a distant part of the body (for instance, the throat). As a consequence, one or more valves can become permanently scarred. The advances in modern surgery have made possible the correction of many of these defects.

Children with heart disease can behave in different fashions. A child with mild abnormality and almost no disability will be indistinguishable from his normal peers. Other children can have marked diminution in their tolerance to physical exercise, due to more severe involvement. Another group constitutes the children with a mild disease but who will be so anxious that they will behave as if their disability is great. More often than not this is a direct influence from home and reflects the way parents adapt themselves to the situation. A child with a heart disease generally knows his limits. It is not necessary to restrain him from everyday exercises. Those children whose tolerance is markedly diminished will need help adjusting to the situation. *They are different from other children, and cannot participate in all the classroom activities.* With your help, he will be able to recognize his limitations, but at the same time be able to gain confidence by developing the skills at which he or she is at his best. By developing his full potential the child with heart disease, as well as any other handicapped child, will have a better adjustment to life.

J. MENTAL RETARDATION

Mental retardation means impairment of intellectual function so that a child cannot perform mental tasks such as thinking, understanding, and communicating at his age level. His mental functioning is more like that of a younger child. The retarded child appears "dull" or "slow." Mental retardation stems from a poorly functioning brain. In contrast, a child may have delayed development (for example in the area of speech) because of poor hearing. Although at first glance his speech may be just as behind as that of a mentally retarded child, this child is not said to be retarded. Often, but not always, retarded children show delays in motor development, being slow to stand, walk, climb, toilet train, etc.

Any injury which can damage the brain can lead to permanent impairment of brain function and mental retardation. One cause of injury is an infection of the brain. Such an infection can occur prior to the baby's birth (in utero), as with *German measles* (Rubella) virus. The ability of this virus to harm a fetus is the major reason for the program of immunization against German measles. After birth, infection of the brain and spinal cord (encephalitis and meningitis) can cause permanent damage. This danger

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of brain damage accounts for the intense concern which doctors have about the early identification and treatment of these infections. Another common cause of brain damage is injury to the brain, as can occur when a child is hit by a car or is inside a car involved in a collision. (Automobile accidents are a leading cause of death and disability in children after the period of infancy, making urgent the necessity for using seat restraints while traveling in motor vehicles.) Prematurity of birth, which can be accompanied by a temporarily lowered oxygen supply to the brain, can be associated with mental retardation and is of increasing importance in this regard now that modern techniques permit the saving of many prematurely born babies who would never have survived in years past. Lead poisoning (a completely preventable disease which is still tragically a problem in the United States) can permanently damage the brain. Genetic defects involving abnormal chromosomes can result in the birth of multiply handicapped children with disorders such as Down's Syndrome (previously called Mongolism). In these children the brain is malformed, which is reflected in a general retardation of development. Chemical disorders like Phenylketonuria (PKU) can, if untreated, damage the brain. For this reason all newborns receive blood tests for PKU. If the condition is present, a special diet is begun to prevent the accumulation of the chemical in the blood responsible for the brain damage. Probably the leading worldwide cause of mental retardation is malnutrition. In this country lack of a proper diet in infancy and childhood undoubtedly plays a role in children from impoverished families. In most children with mental retardation, no cause can be identified and, accordingly, no preventive measures are available. Further research is needed.

In general, there is no correction for the abnormality in the brain which has caused retardation. Whether a child will progress depends on the severity of the brain defect and the supportiveness of his environment. The rejected child will have little motivation to develop to the maximum of his capacity. The retarded child has the same basic need for love and understanding as the normal child. It is not helpful to label the child as retarded and then write him off as someone who is a lost cause. It is important to understand him as an individual with strengths and weaknesses and a personality that make him unique. Helping him develop to his fullest capacity as a person is the overriding goal.

K. SICKLE-CELL ANEMIA

Sickle-cell anemia is not generally considered a handicapping condition. However, when the anemia is severe, the child may require hospitalization, and children with sickle-cell anemia may tire easily and tend to get infections frequently. Therefore, it is helpful for the teacher to be aware of some of these factors affecting the child's adaptation to the program.

Sickle-cell anemia is an inherited disease, primarily affecting Blacks, in which the red blood cells flatten out in the shape of a half moon (sickle). These red blood cells do not survive in the body as long as do normal cells (120 days) and form small clots which lead to attacks of pain and impaired functioning of parts of the body. In general, the production of new red cells cannot keep pace with the constant removal of the sickled cells, and this imbalance accounts for the anemia, which means too few red blood cells. Sometimes the rate of red blood cell destruction is markedly increased. At other times the production of new red cells is temporarily stalled. Both situations increase the severity of the anemia.

Children with sickle-cell anemia are chronically ill but as in all diseases, the intensity of symptoms varies from one child to another and in the same child from one time to another. Often the child will look normal except for gangly arms and legs and a yellowish tint (jaundice) to the eyes. When the child is sick, you may notice easy tiring, paleness (seen best in Black children in the nail-beds and inner parts of the eyelid), susceptibility to infection, attacks of pain (commonly in the abdomen and extremities). When the anemia is severe the child develops shortness of breath and fatigue, which may require hospitalization. At present there is no cure for the disease itself, although severe anemia and painful attacks can be treated.

When the anemia is not severe, children with sickle-cell anemia require no special precautions by the teacher. They can be fully active. Treat these children just as you would normal children.

To have sickle-cell anemia, the child must inherit the tendency from both his father and mother. His parents are said to be carriers of the tendency (trait). If only one is a carrier, the child cannot have the disease but may be a carrier. A carrier does not have symptoms except under extraordinary circumstances, but a carrier's red blood cells can be made to sickle under proper laboratory conditions. Knowing that one is a carrier is important information in terms of having children. One might avoid marrying another carrier and thus avoid the possibility of having affected children. When two carriers marry, there is a one in four chance that any given baby will have sickle-cell anemia, a two in four (one in two) chance of having a child who is a carrier, and a one in four chance of a child who is neither a carrier nor sick with the disease.

There is little practical point in knowing whether a child is a carrier before the reproductive years except perhaps to

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encourage the parents to have themselves checked. A good time to check children is in high school. Carriers are not ill or at risk for developing any complications. The information about the carrier state is useful primarily to guide decisions about reproduction. There is a danger that people may think that there is something wrong with a child who is a carrier because they do not understand the difference between being a carrier and having the disease.

L. VISION IMPAIRMENT

Approximately one child out of ten enters school with some sort of visual impairment, which in many cases interferes with his adaptation to and performance in school. The most common cause of correctable decreased vision in childhood is significant refractive problems. Refractive problems are those which can be corrected by glasses. The three types of refractive problems are farsightedness, nearsightedness, and astigmatism. Sometimes the amount of defect is greater in one eye than the other. Each can be corrected with spectacles following an accurate measurement of the defect. This testing is called a refraction and in children often requires premedication with eye drops.

Children with excessive farsightedness (hyperopia) have more difficulty with near than distant vision. Their only

symptoms may be early fatigue and relative inattention to near tasks such as writing, reading, workbooks, etc. Frequently such children become cross-eyed between the ages of three and five years. This deviation may be very variable and intermittent. Visual testing may show only a mild loss of distance vision greater on one side than the other.

The nearsighted child may have very blurred distance vision and see things well that are near. No amount of effort except narrowing of the lids (squinting) can bring distant objects into clearer focus. Reading material is held close. When glasses are prescribed for significant nearsightedness, children wear them eagerly and often a noticeable increase in interest in activities can be observed.

Astigmatism is caused by a defect in curvature of the front of the eye. A small amount of astigmatism may be present with farsightedness and nearsightedness, or when excessive it may be the principal problem. It usually causes mild to moderate degrees of visual impairment causing symptoms of visual fatigue. Correction is readily achieved with spectacles.

Another cause of visual impairment in growing children is strabismus, also known as crossing of the eyes or "lazy eye." This results from imbalance of the muscles which move the eyeballs, or from visual defects such as farsightedness in one or both eyes. When crossing occurs, for whatever reason, unpleasant double vision results. To prevent this uncomfortable sensation, the child stops using one eye by suppressing vision in it. Only one eye is used in seeing. The act of suppressing vision is familiar to anyone who has tried to look with one eye through a telescope. Constantly suppressing vision in an eye is dangerous in that with time the eye will lose its capacity to see, to the point of permanent blindness in that eye. Therefore, early identification and treatment of crossed eyes is of urgent importance.

Treatment involves correction of the underlying cause of the crossing, through glasses or through surgery to realign imbalanced muscles, and reversal of loss of sight in the suppressed eye by placing a patch on the good eye (the one doing all the work). Then the child is forced to use the impaired eye. If treatment is begun early enough, its vision should improve.

In some children with visual defects, their vision is still quite defective even after correction. However, these children are still able to read print. Children with this type of problem are referred to as visually impaired. Visual impairment may be caused by injury to the unborn child, or by disease or accident occurring later.

Children with visual impairments may have slower language development; however, their intelligence and educational capacity are substantially the same as other children's. The major classroom adaptation to be made for such children is to add training experiences so that the remaining vision is used, and to help the child use touch and hearing to supplement his impaired vision. Such classroom adaptations are described in the section on "The Blind Child."

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VII. Concluding Section

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In any Head Start program it may happen that certain children have problems that lead the staff to desire additional services beyond what is offered in the classroom. While all handicapped children may experience significant gains in the Head Start program, the classroom intervention alone cannot always fully deal with the entire problem. In such cases it is helpful to know what specialists in speech, behavior problems or physical problems are available in your community. It is realistic to recognize that a specialist may provide services that can support the child's classroom experience in crucial ways.

Deciding when to refer a child for special services, and finding out where to turn for help are the first steps in the process of obtaining additional assistance. The next step is a discussion of the staff's observations and suggestions with the child's parents. In many cases parental cooperation is what ultimately decides whether or not the child gets the help he needs. Because the parents' cooperation is essential, it is relevant here to consider generally the development of good relations between staff and parents. It is these good relations which form the foundation for assisting the child. In this chapter you will find some suggestions about the different steps in the process of providing for the child special assistance beyond the classroom.

A. TALKING WITH PARENTS

Head Start is only one part of the child's day. Being in preschool affects the child's family life and his general growth and adjustment. Similarly, what goes on outside of class, at home, and in the neighborhood also affects the child's behavior in Head Start. Thus, for both parent and teacher even a small effort toward keeping each other informed will always be helpful. And where problems appear, consultation between teacher and parent becomes crucial. Within the social service department, the neighborhood worker has an important function in preserving a flow of information between parents and teachers.

WHY TALKING TOGETHER IS IMPORTANT

On the teacher's part, simple friendliness can go a long way to establish good feelings toward Head Start in general. The child is not the only one who feels that the teacher is an unknown, slightly threatening authority; parents often feel that way, too. When a teacher shows she is willing to hear a parent out, or makes a point of speaking in a friendly way, she makes the parent feel less *outside* of the program, more a part of it.

But, of course, it is not just a matter of making parents feel more comfortable. Specific information is often needed. The teacher's daily job is made easier when she is told about things that are important to the child: e.g., that the parents are going out of town next weekend; that this child's newborn brother is coming home Tuesday; that Tommy's dog has been lost for two weeks. The child himself may tell you these things, or he may not. But the teacher can show parents that she's interested in general family news. In the long run, this pays off by helping the teacher better understand and anticipate the child's reactions. Similarly, things will go more smoothly if the teacher informs the parents about things such as the planning of a special trip, appropriate clothing needs, about the child's special interests, or problems with which she needs parental cooperation.

LISTENING TO THE PARENT

There are many different ways in which parents and staff may talk together. Regularly planned home visits are perhaps the most typical way. Here, parents are informed of the child's general progress in the course of the year, and the informal atmosphere gives parents the chance to see teachers as more "human" figures. But other times and places for talking together necessarily occur. When parents deliver and pick up their children, there is a daily opportunity for some talk. This can be extremely useful. Thus, especially at the start of the program year, it is well for the teacher to tell parents, "You know, I'd always like to hear from you if something goes on that you think is important to Jimmy. It helps me understand him better." Of course there can be drawbacks if conversations take place in the morning as the program is about to start. Some parents may want to tell you too much and keep you too long. You can excuse yourself politely, or if you feel the parent really needs to talk, suggest another time. Some parents will be saying things in front of the child that you would rather the child didn't hear. You can handle this situation either by directing the child into some activity or by asking the parent to wait to talk at another time. But despite the occasional drawbacks, much good comes from letting the parent know his comments are valued by the teacher.

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TALKING TO THE PARENT

Sometimes the teacher will find that she wants to know more about why a child acts in such and such a way. Or the teacher will want to tell a parent about Susie's behavior in school. Both may be difficult to accomplish, especially if the child is in trouble. While it is relatively easy to suggest to a mother that she leave Susie's good coat at home and dress her in play clothes instead, it is less easy to tell a mother that Susie is constantly running into the street, or that James is taking too much satisfaction hurting other children. Both teacher and parent may have uncomfortable feelings about discussing such things. The teacher may be afraid of hurting the mother's feelings or she may be reluctant to show her own uncertainty and distress. The parent may feel that she is being blamed, or is being called a bad mother for something her child has done. Such feelings may make a teacher put off talking to a parent. But delay doesn't particularly help. It *does* help if you have managed to create all along the idea that it is the most natural thing in the world for parents and teachers to talk together.

WHEN REFERRAL IS NECESSARY

When really serious problems need to be discussed, casual contacts at the classroom door are no longer sufficient or effective ways to communicate with a parent. Within the social service department the neighborhood worker or community aide will need to be informed in some detail of why the teacher is concerned. In our experience ordinarily the neighborhood worker or community aide will visit the parents to discuss the child's problem. In some situations in which there is agreement that the mother has related more constructively to the teacher than to the neighborhood worker, the teacher may be asked to try to persuade mother to consult a health or child guidance clinic about her child's needs.

Usually, though not always, it is easier for the mother to follow through on recommendation for referral from the neighborhood worker or teacher when the problem is a physical rather than a behavioral one. What is usually needed is an account of the teacher's observations of the child's physical problem and information about an appropriate resource for help. One needs to be sure the mother knows how to get to the clinic that is recommended and how to make an appointment if one is necessary. Usually a follow-up visit or phone call is helpful, both to know whether mother succeeded in getting the child seen at the clinic, and whether the clinic recommendations included anything that should be done for the child while he is at Head Start.

In some exceptional instances when a mother is so frightened that she denies her child's signs of illness or when the issue of general neglect is involved, then it may be difficult for the mother to follow the staff recommendations. But if facilities are genuinely available for the child and their cost is not too much of a burden, parents will usually be able to follow through on a child's physical problem.

When the child's problem is an emotional or behavioral one, the process of referral may be more difficult; nevertheless, there are certain situations when Head Start staff will need to consider referral and to decide together how to try to get the parents to accept it. We have listed below some of the kinds of behaviors that will usually alert teachers and the social service staff to the need for referral for evaluation at a child guidance clinic or hospital.

WHEN TO CONSIDER REFERRAL FOR EMOTIONAL OR BEHAVIORAL PROBLEMS

1. When any of the following behaviors have been evident repeatedly over an extended period of time (2-3 months). Most of these behaviors have been discussed in more detail in chapters indicated.

- ☐ Markedly withdrawn, nonsocial attitude (Chapter V)
- ☐ Lack of speech (Chapter III)
- ☐ Repeated aggressive or destructive behavior (Chapter V)
- ☐ Markedly immature behavior: i.e., crawling, crying, clinging (Chapter V)
- ☐ Self-hurting behavior (Chapter V)
- ☐ Running away from center, into streets (Chapter II)
- ☐ Noticeable confusion in thinking (Chapter III)
- ☐ Strange, unusual behavior (Chapter V)
- ☐ Suspected retardation (Chapter IV)
- ☐ Suspected child abuse (Chapter V)
- ☐ Severe preceptual-motor difficulties (Chapter III)

2. Single dramatic behaviors warrant communication with the family and may warrant referral:

- ☐ Seizures, fainting (Chapter VI)
- ☐ Running away from center, dangerously in front of cars (Chapter V)
- ☐ Child's saying he is planning to run away, do something dangerous (Chapter V)
- ☐ Severely aggressive or destructive behavior to others or self (Chapter V)

SUGGESTIONS ABOUT THE PROCESS OF REFERRAL

Naturally, before speaking to parents you need to have clearly in mind why you feel referral is advisable, and *where*

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you feel parents should turn. (See local resources listing.) Then, in communicating this information to parents, bear in mind that this may be extremely frightening or upsetting news. Parents will tend to hear only one thing: "You're saying he's bad and we're bad." This kind of feeling may be lessened if:

1. Staff takes the time to lead up gradually to the business of referral. If possible, do not introduce referral at your first discussion of the child's behavior. This is not only to avoid hurt feelings. A parent who feels too shocked or guilty will be less able to follow through on your advice. Giving the parent time to get used to the idea of a problem will help the parent actually carry out your suggestions.

2. Describe exactly what has been observed in Head Start and explain why staff is concerned. BE SPECIFIC. Ask if parents have seen the same thing at home. Encourage them to talk freely about it.

3. Say that you know the parents feel upset about this but emphasize that it is a question of help, not of anybody's having done anything wrong.

4. Make your suggestions very clear. Write out any information you have to give about agencies.

5. Before ending the discussion, plan for another time to talk, even briefly, about what is being done.

Not every parent will take the suggestions about referral at the time they are given. Parents of young children naturally would like to think the child will "grow out of it." When the problem is a very severe one, the Head Start staff will be especially concerned in repeated contacts with the parents to emphasize the value of early intervention.

B. WHERE TO TURN FOR HELP

When the teacher and the social service worker have decided that a child has not responded well to the usual classroom procedures, it is advisable to seek help from an appropriate social service agency, hospital, or health facility in your community. The person to turn to first is your Head Start Social Service Coordinator at the grantee level. He (or she) is familiar with the local resources and can direct you to the proper agency or clinic. This person can also help you make the initial contact. Here are some examples of the types of resources to which you may be referred. In a small town rural area a possible resource for referral of handicapped children is the State Welfare Department. In a large town or city the United Community Services will usually be able to refer you to the resources you need.

One or more of the following services, if available in you area, is likely to be able to provide actual evaluation, diagnosis, and/or treatment, as needed:

GENERAL HEALTH SERVICES
- Community Hospital
- Well-Baby Clinics
- Public Health Clinics
- Child Development Clinics
- Neighborhood Health Clinics

SPECIALIZED CLINICS
- Eye Clinics
- Speech and Hearing Clinics
- Orthopedic Clinics
- Rehabilitation Centers

MENTAL HEALTH CENTERS
- Community Mental Health Centers
- Child Guidance Clinics

COMMUNITY CENTER SERVICES
- Community Action Agencies
- Community Welfare Councils
- Welfare Offices
- Neighborhood Centers

If specialized resources are not available locally, you may need to turn to national organizations. Many of these have local chapters, so check your phone book before contacting the national office.

GENERAL RESOURCES (Agencies that will act as general referral resources for the evaluation, diagnosis, and treatment of the special child)

Organization

American Academy of Pediatrics
1081 Hinman Avenue
Evanston, Illinois 60204

Child Welfare League of America, Inc.
67 Irving Place
New York, New York
212 254-7410

Closer Look
Box 1492
Washington, D.C. 20012
(Closer Look acts as a good resource. It will send you information about services in your area that provide care for the special child.)

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The Council for Exceptional Children
1411 S. Jefferson Davis Highway
Arlington, Virginia 22202
703 521-8820

National Association of State Directors of Special Education
c/o Dr. Elwood Pace
Division of Special Education
State Department of Education
Salt Lake City, Utah 84111

Office of Education
Bureau of Education for the Handicapped
Seventh and D Streets, S.W.
Washington, D.C. 20202

BLINDNESS AND VISUAL PROBLEMS

American Foundation for the Blind
15 West 16th Street
New York, New York 10011

American Printing House for the Blind
1839 Frankfort Avenue
Louisville, Kentucky 40206
502 895-2405

American Association of Workers for the Blind, Inc.
1511 K Street, N.W.
Suite 637
Washington, D.C. 20005
202 347-1559
(Publishes braille books for blind and partially seeing – Braille music, talking books, educational materials – Write to them for a listing of materials)

Library of Congress
Division for the Blind and Physically Handicapped
1291 Taylor Street, N.W.
Washington, D.C. 20542
202 882-5500
(National reference and referral service)

CEREBRAL PALSY

American Academy for Cerebral Palsy
University Hospital School
Iowa City, Iowa 52240
319 353-4825

United Cerebral Palsy Association, Inc.
66 East 34th Street
New York, New York 10016
212 889-6655

CYSTIC FIBROSIS

Cystic Fibrosis Foundation
202 East 44th Street
New York, New York 10017

DEAFNESS, HARD OF HEARING, LANGUAGE DIFFICULTIES

Alexander Graham Bell Association for the Deaf, Inc.
317 Volta Place
Washington, D.C. 20007
202 337-5220

The American Speech and Hearing Association
9030 Old Georgetown Road
Washington, D.C. 20014
301 530-3400

National Association of the Deaf
814 Thayer Avenue
Silver Spring, Maryland 20910
301 587-1788

Council of Organizations Serving Deaf
4201 Connecticut Avenue, N.W.
Washington, D.C. 20014
202 363-5611

National Association of Hearing and Speech Agencies
919 18th Street, N.W.
Washington, D.C. 20014
202 295-3844

EMOTIONAL PROBLEMS, LEARNING DISABILITIES, MENTAL RETARDATION

The American Association of Psychiatric Services for Children
1701 18th Street, N.W.
Washington, D.C. 20009
202 332-7071

American Humane Association, Children's Division
P.O. Box 1266
Denver, Colorado 80201
(A national organization that will refer you to local affiliated services.)

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American Psychiatric Association
1700 18th Street, N.W.
Washington, D.C. 20009
202 232-7878

Association for Children with Learning Disabilities
2200 Brownsville Road
Pittsburgh, Pennsylvania 15210
412 882-5201

Family Service Association of America (Mental Health Problems)
44 East 23rd Street
New York, New York 10010
212 674-6100

League for Emotionally Disturbed Children
171 Madison Avenue
New York, New York 10017

The National Association for Mental Health, Inc.
Box 610
Lawrence, Kansas
913 842-1909

The National Association of Coordinators of State Programs for the Mentally Retarded
Suite 802
Crystal City Plaza #1
2001 Jefferson Davis Highway
Arlington, Virginia 22202
703 920-0700

National Society for Autistic Children
621 Central Avenue
Albany, New York 12206

President's Committee on Mental Retardation
Washington, D.C. 20201
202 963-5819

EPILEPSY

Epilepsy Foundation of America
1828 L Street, N.W.
Suite 406
Washington, D.C. 20036

National Epilepsy League, Inc.
222 North Michigan Avenue
Fifth Floor
Chicago, Illinois 60612
312 332-6888

United Epilepsy Association, Inc.
111 West 57th Street
New York, New York 10019

PHYSICAL DISABILITIES

American Physical Therapy Association
1156 15th Street, N.W.
Washington, D.C.
202 466-2070

Association for the Aid of Crippled Children
345 East 46th Street
New York, New York 10017
212 697-3150

Library of Congress
Division for the Blind and Physically Handicapped
1291 Taylor Street, N.W.
Washington, D.C. 20542
202 882-5500
(National reference and referral service)

Muscular Dystrophy Association of America, Inc.
1790 Broadway
New York, New York 10019
212 586-0808

The National Easter Seal Society for Crippled Children and Adults
2023 West Ogden Avenue
Chicago, Illinois 60612
312 243-8400

The National Foundation March of Dimes
P.O. Box 2000
White Plains, New York 10602
914 428-7100

National Multiple Sclerosis Society
257 Park Avenue South
New York, New York 10010
212 674-4100

National Paraplegia Foundation
333 North Michigan Avenue
Chicago, Illinois 60601
312 346-4779

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Appendix I

MATERIALS AND IDEAS

Every year when Head Start teachers set up their classrooms and plan their programs, the task of ordering and collecting supplies must be undertaken. But before you draw up lists and submit orders, there are some important questions to be answered:

1. How many children will you have in your class? *
2. What supplies now in stock are in good working condition?
3. What can be restored to usefulness with new paint or simple repairs?
4. What useful material can you get free?
5. What children with special needs will be in your class?
6. Will these children require special spatial or mechanical accommodations?
7. What area in your classroom needs the most rethinking and refurbishing?
8. Is there some entirely new concept or plan you'd like to try in the arrangement of your classroom?
9. Is there a new aspect of your program you'd like to develop?

In order to plan realistically you will have to know how much money is set aside in your budget for equipment and supplies. Ask your supervisor or program director to show you a copy of your budget. Budgets are generally broken down into two categories: equipment and supplies. The item "equipment" usually covers standard permanent furniture and toys. Tricycles, easels and dolls are some things that might go under that category. The item "supplies" includes expendable materials which need to be ordered every year: magic markers, paper and lotto games.

Your wants and needs are likely to exceed the amount you have to spend. You will have to decide what you need most. Look for materials that are versatile and durable, and can be put to uses that will have beneficial results for the development of the whole child.

The following is a list of materials which are beneficial for all children, including children with special needs. You will see that many of them will already be found in your classrooms. Some can be scrounged, some can be improvised or homemade and others will have to be bought. The list has been broken down into curriculum areas, with specific suggestions for skill-building and concept-formation with handicapped children.

I. **Gross Motor Activities** – for children who have trouble with large muscle activities, coordination and body awareness.

1. *Irish Mail* – Ride-on toy operated by arm lever; good for a child who can't pedal, but wants to ride around. This toy teaches the difference between pushing and pulling and develops arm muscles.
2. *Platforms on wheels* – Lying tummy down and moving with arms.
3. *Inchworms** – Good for developing leg movement for a child who may have moderate impairment.
4. *Krazy Car, Wildrider** – Hand-operated cars; good for the child who can't operate foot pedals.
5. *Scooter car* – Tot bikes (these are like tricyles but they have no pedals), velocipedes; good as a trainer for tricycle riding. Children do not need reciprocal motion to ride these.
6. *Big Wheels** – Children prefer these to tricycles because of their style and color. They have a broad base, are practically indestructible.
7. *Metal ride-in cars* – Like fire engines, trucks, etc. Good exercise for developing leg muscles; high sides help children with balance problems.
8. *Rocking horse* – Good for the unsteady child or the child who can't walk; develops arm and leg muscles.
9. *Rocking boat* – Two or more children love to rock back and forth in these boats; can be tipped over and used as stairs.
10. *Sticks with horse heads* – These horses are fun to ride; a child can walk, trot, or run with them.
11. *Rubber belt swings* – These swings are easier to keep your balance on than the flat metal swings.
12. *Chair swings* – Good for a child who doesn't have as much gross motor control as his peers. Even if

*denotes commercial name.

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he can't pump, he can be pushed and swing like the rest of his classmates. Because of the bar across the front and the high back, children with balance problems cannot fall out.

13. *Double swing* – Operated by two people with hands and feet, good exercise for pushing and pulling; a nice lesson in cooperation.
14. *Jumbo cardboard or wooden blocks* – For carrying around and building.
15. *Large cardboard tubes* – Good for crawling through, rolling on, and sliding.
16. *Old large wire spools* – These are for rolling and rolling on. You can get these from electrical wiring companies and telephone companies.
17. *Tires* – Good for climbing on, jumping on and throwing things into; sometimes children use them for trucks or gas station play. Can be used as a swing.
18. *Blow-up knock-down toys* – Can be fixed with tire patching kit; fun to roll on, roll and knock down because they keep popping back up (e.g., Bobos, Bozos)
19. *Sandbox* – Kids who can't walk or who are unsteady can play just like any other child when they're in the sandbox. There are so many things to do with sand: digging, sifting, pouring, making roads and castles.
20. *Child-size snow shovels* – Good for developing arm muscles, encouraging dramatic play and gardening.
21. *Large beach balls* – For rolling, throwing and catching.
22. *Clutch balls* – Balls with ridges for grabbing; easier to hold than hard balls; soft, cozy, fun to throw, safe in a classroom.
23. *Nerf Balls®* – Easy to hold and throw; they're lightweight and spongy.
24. *Bean bags* – Good for throwing at a target.
25. *Walking board and sawhorse* – Keep it adjusted either flat or very low; fun to walk on; helps child improve balance and gross motor coordination.
26. *Stepping stones* – Place cardboard squares on floor to teach balance, gross motor coordination.
27. *Large appliance cartons* – For crawling around in and building with.
28. *Carriages, wagons, grocery carts* – Filled with some type of weights, for a child who is unsteady or needs crutches, pushing a wagon is fun.
29. *Carpet sweeper, wheelbarrow* – If your classroom isn't big enough, use outside.
30. *Large trucks* – Can be ridden or manipulated by hand while lying or sitting on the floor.
31. *Floor toys* – Cardboard blocks, trucks, rubber or plastic or wooden dolls, rocking boat, interlocking wooden trains, hardwood unit blocks, stepping stones, balance beam, tumbling mats, water play trough, allow children gross motor activity within the classroom, help them to balance themselves and coordinate gross motor movements.

II. Fine Motor Problems, Perceptual Motor Problems

1. *Lego Jumbo®bricks* – Simple, large construction toys with easy interlock; Jumbo Legos are easy to manipulate. The child who has problems with manual dexterity will be able to build structures that he couldn't build with smaller blocks.
2. *Large nuts and screws* – It's fun to be just like adults who work with tools. And, these large nuts and screws develop hand movements such as turning and grasping; they also help with size and shape discrimination and matching. Can get real ones at hardware store or plastic ones designed especially for children.
3. *Magnets* – Can be used for many different things. Spread out all kinds of items on the table and see what magnets can and can't pick up. Magnets are a fun introduction to science.
4. *Play Plax®, play rings* – Colorful almost indestructible building toy good for fine motor and perceptual motor practice.
5. *Shapes®* – More pliable and different shapes, these are good in a manner similar to Legos.
6. *Small Lego®* – Children enjoy building with any of these materials. In order to use them, the child has to figure out how the pieces interlock. His coordination and creativity in building different structures come into play with this activity.
7. *Large pegboards* – At least 10" by 10" with 2" pegs, good for manual dexterity, counting patterns, construction; large beads or elastics are fun to put over the pegs.
8. *One or two piece puzzles* – For beginning shape discrimination.
9. *Puzzles with knobs* – These are toys for a child who has fine motor problems. They develop small hand, forearm, and finger muscles.
10. *Large dominoes* – designed for children.
11. *Snap together beads* (large pop-it beads) – Fun to

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make; children enjoy wearing these beads as bracelets and necklaces.

12. *Stacking toys* – These toys fit one inside the other; they teach the concept of size as well as improving manual dexterity and balance.
13. *Large tops* – Fun to spin; they teach rotary motion and develop arm muscles.
14. *Clothes pins* – For dropping into milk bottle; teaches aim, counting, taking turns; good rainy day activity.
15. *Threading block** – A wooden block with holes in it and an attached lace. Good for improving manual coordination and learning in, out, around and through.
16. *Busy box* – A simple manipulation toy with various gadgets which are moved by hand. Very young children, retarded children and children with control problems seem particularly attracted to it.
17. *Button board* – Helps a child with fine motor or perceptual motor problems develop self-help skills. Good for retarded children too.
18. *Jumbo gear board* – These toys can be either wall or lap boards in order to allow the child who has motor problems access to them. They help strengthen fine motor skills and teach a continuous turning motion.
19. *Wall or table geoboards* – String or rubber bands around the nails to make design or shapes.
20. *Waterplay items* – Straws, bubble pipes, short ends of hose, cups (not metal), squeeze bottles, things that float, toy boats, bathtub toys, rubber dolls, plastic dishes from housekeeping corner, doll clothes, sponges. Waterplay can range from floating a lightweight toy on water to washing plastic dishes. Children learn about weight and mass. Also simple manual skills like squeezing and grasping are developed. Needs some supervision but it is a worthwhile activity.
21. *Corn meal* – In small dishpans; a good tactile experience. Can be used for shifting, measuring, pouring, spooning, stirring.
22. *Salt* – Same uses as corn meal.
23. *Jack-in-the-box* – The child is rewarded for turning the crank because jack pops up.
24. *Pounding benches* – Helps the child develop manual skills. For aggressive children it's a good outlet for frustration. Teaches top from bottom and concept of turning over.
25. *Tracing* – Helps the child develop eye-hand coordination.
26. *Stencils* – Not to be considered as an art media but good for perceptual motor training and learning to direct a pencil.
27. *Stickers* – Pictures with gummed backs for pasting; can be used on a plain piece of paper for perceptual motor training, or task may be made more difficult by having child stick sticker in outline.
28. *Large beads and strings with shoelace ends* – These beads should be bright and colorful to be attractive. They're easy to string for most children and just perfect for helping to improve the dexterity of those children with fine motor problems. It introduces names of colors. Children love to wear the beads as necklaces and bracelets.

III. Art Activities

1. *Crayon and stick* – For children who can't grasp at all. Attach crayon to stick and stick to child's hand. This enables the child to express his creativity as well as participate in the same activity as the rest of the class.
2. *Sponge paint* – Cut the sponge into small, handy pieces. Easier to grasp than potato prints or paint brushes, sponge painting is a good creative experience for a child.
3. *Brush painting* – Use ¼" to ½" stiff brushes for children with manual dexterity problems.
4. *Painting with feet* – Good tactile experience for children who cannot grasp.
5. *Finger painting* – For the child who has fine motor problems, finger painting is special fun. It's all right to make a mess and every creation is a unique painting.
6. *Shaving cream* – Can be used directly on the table for finger painting.
7. *Large chalk, magic markers and crayons* – Easy to grasp; for a child whose fine motor coordination needs improving, these large art tools are very helpful.
8. *Tearing collage* – Children use different pictures to make a picture of their own. The child works on tearing, glueing and placing his materials to design a picture. Tearing is easier than cutting and a good exercise.
9. *Cutting* – Teaches motor skill. It is a perceptual motor task involving aim, directionality, and continual motion.
10. *Glueing* – Almost anything is fun to glue together. We have included a sample "Beautiful

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Junk" list which one might send to parents in order to obtain glueing materials. (See section VII of Appendix I.)

11. *Glueing large objects, 3-D sculpture* – Large objects are more easily manipulated than smaller items. Using large objects in art for children with fine motor problems allows them both to be creative and improve manual skills such as grasping, placing objects, and glueing.
12. *Rigatoni* – Large macaroni; can be strung on shoelace-end strings and/or glued to a piece of paper to make a collage. This medium can be used to develop fine motor dexterity. Rigatoni can also be used for work with numbers.
13. *Clay* (modeling clay, grey potter's clay) – Even for children with severe fine motor problems, this is a very good expressive medium. All children enjoy and are able to pound, squeeze, and roll the clay. It's good for helping children release tension. There is never any failure involved; each child creates something on his own level.
14. *Play dough* – Recipe: 3 cups flour
    1 cup salt
    water to mix
15. *Paper bag puppets* – The child enjoys using puppets he makes. The child learns body awareness by having to properly order facial arrangement. Manual skills of cutting, pasting, and/or drawing are also developed through this medium. A great way of getting a child to verbalize and act out his feelings. Puppets can be made from paper plates too.

IV. Language Activities – For language-deprived children and children with expressive problems.

1. *Field trips* – 1) Prepare child before the trip, 2) discuss afterwards (use experience charts). Field trips take lots of thought and planning. Discussing where you are going and what you will see always helps to prepare children. Transportation to and from the trip should be mentioned too, be it walking or driving. Follow-up with the children helps to reinforce what they did and saw. Experience charts make everyone feel that their impressions of the trip are important. Constitutes a reading readiness activity. This is a good way to involve parents in your program. Bring them along to help you supervise.
2. *Neighborhood walks* – With follow-up language activity. These walks encourage children to observe their immediate environment and then talk about what they saw.
3. *Smelling bags* – Put perfume, coffee, lemon peel, orange rind, cotton soaked with vanilla or almond extract, for example, in a small container and let the children discuss the differences between aromas.
4. *Feeling boxes* – Shoe boxes filled with many different objects; old pieces of cotton, velvet, fur or corduroy, piece of sandpaper, button, foam rubber, rocks, feathers. Let children discuss the differences between textures.
5. *Doctor's kit* – Used by children, a doctor's kit teaches about health and promotes peer interaction. It lessens the fear of going for a check-up and reinforces the concept of community helpers. For a child who is being hospitalized or was recently hospitalized, it reduces the anxiety he feels, and gives him a chance to express his experiences through dramatic play.
6. *Nonsense rhymes and simple rhyming games* – Rhyming promotes auditory discrimination and the basis for a later enjoyment of literature.
7. *Category games* – Q: I'm going to the zoo, what would I see? A: Mo.ket, beach, playground, farm. Reinforce field trip experiences, increase vocabulary, and develop the concept of classification.
8. *Impromptu characterization of children's stories* – e.g. Three Bears, Caps for Sale, Billy Goats Gruff. Children have a chance to act out stories they've already heard. This dramatization is a combination of verbalization, listening, self-expression and social awareness.
9. *Dress-up clothes* – Children enjoy role-play as grownups or other children. This reinforces concepts of family and community constellations (i.e., fireman, policeman, doctor, mailman). Promotes socialization.
10. *Housekeeping corner* – Broom, carpetsweeper, child-size table and chair, plastic dishes, pots and pans, doll bed, dress-up clothes, mirror, toy appliances (nice if you can afford them; but don't forget they can be homemade too. Save empty food cartons and cans so kids can cook and serve with them), kitchen utensils. This corner is good for dress-up and other kinds of dramatic play. It encourages verbal interaction between children.
11. *Guessing games* – Enhance creative ideas, problem-solving and verbal interaction.
12. *Telephones, toy or real* – Check with your phone company and see what they will lend or donate.

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Develops conversational skills, social skills, and number identification.

13. *Flannel boards* – When working on their own, children enjoy using flannel boards to make up stories. When working with the teacher, various concepts can be introduced or reinforced (i.e., family, nutrition, numbers and science).
14. *Picture file* – Magazine pictures and/or teaching pictures; gives children a chance to make up their own stories thereby developing their imaginative and verbal abilities.
15. *Lotto* – Teaches the child to match visually, visually associate, and identify objects.
16. *Show and Tell* – Gives each child a chance to tell something important about himself. This activity is an introduction to speaking in front of a group.
17. *Puppets* – If you don't have puppets you can draw a face with a pen on a child's thumb. Start a conversation. Children often find it easier to express themselves through the puppet than speaking directly to you.
18. *Doll houses* – Children like to play make-believe with their friends. Dolls and doll house activities help the child express his emotions through imaginative play and reinforce the child's familiar concept.
19. *Records* – 1) game records (e.g., Going to the Zoo) – Children pretend they are different characters.
    2) story records – Children listen and are attentive to these stories.
    3) music – teaches rhythm, songs; enhances auditory discrimination and word building.
20. *Photographs of the children* – Reinforces the child's self-concept; promotes verbalization.
21. *Books* – Assist in developing attention span, teach children new concepts. Being positive while reading to the class helps make children want to be able to read by themselves. Here are a few suggestions for reading to preschool children:

    > Children like books with lots of pictures and few words. Hold the book at an angle that allows all children to see the pictures. Read the book by yourself first so you know the story. Let the children tell you what they see in the pictures and what they think is going to happen next.

22. *Guessing common noises* – Children close their eyes while teacher or another child turns on radio, rings bell, sneezes, snores, makes train noises, animal noises. Helps develop auditory discrimination and identification of sounds.
23. *Whisper games* – Children learn to differentiate voice pitches and interpret what they hear.
24. *Verbal sequence* – 1) Someone starts a story, stops and the next child continues the story. 2) Experience chart which sequences field trip activities. 3) I must go downtown . . .4) Song: Aichen Drum, Old MacDonald Had a Farm, Farmer in the Dell, B-I-N-G-O, Ten Little Indians, Where is Thumbkin?, Head Shoulders Knees and Toes, Eency Weency Spider, I'm a Little Teapot. Help children organize thoughts and verbalize them in proper sequence.

V. Activities Which Promote Intellectual Development

1. *Matching* – Dominoes, simple concentration, Lotto, fit a space, Candyland, Winnie the Pooh, match-mates (alphabetized and numerical puzzle cards), parquetry design cards and blocks, 1" cubes and 1" cube design cards.
2. *Sorting* – Beans, peas, macaroni, etc.; colored beads, shape blocks; baseball cards; pictures; graded cylinder blocks; poker chips; mailboxes; sorting boards; flannel boards; magnetic boards; colorforms; picture Lotto; geometric sorting board. Develops ability to classify objects and recognize similarities and differences, and begin to learn number concepts.
3. *Position in space* – Simon Says, Follow the Leader, Go In and Out the Window, Giant Steps. Help the child develop body awareness, directions (e.g., up, down, left, right), his relationship to environment while participating in a peer group activity.
4. *Sequence activities* – Visual discrimination. Cartoon strip puzzles (put in order), follow the dots (1-5), cuisenaire rods (in order from smallest to largest), stack rings, Kitty in The Keg, sequence cards, colorforms, counter cards, geometric puzzles, form puzzles, Montessori inserts, stack toys, shape inserts. These reading readiness activities help the child learn to discriminate differences of attributes, social awareness of proper sequences.
5. *Shape sorting box* – or Playskool mail box.
6. *Counting activities* – Counting, ordering, number names, and one-to-one correspondence.

VI. Cooking – These simple cooking activities are fun and easy. They allow the children in your class a chance to

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learn about what they eat, how different foods are made, and what's good for them. Cooking also helps improve language skills, fine motor coordination and various number concepts.

1. *Sandwiches* — Spreading and cutting are good developmental skills. Children love making sandwiches.
2. *Chocolate milk* — Pouring, measuring and stirring are all skills that can be developed through making this.
3. *Jello* — Helps understanding of transformation. Changes from warm liquid to solid right before your very eyes. Making it involves careful pouring which helps coordination.
4. *Pudding* — Quick and easy. Stirring the pudding over a low flame brings about a gradual change in its consistency.
5. *Frozen juices* — Needs to be shaken and children like doing it.
6. *Popcorn* — Easy to make and children like the popping noise of the kernels. The kernels are changed from small, yellow, dried seeds to large, white popped corn.
7. *Lemonade* — Squeezing lemons to make lemon juice helps to develop manual strength and coordination.
8. *Fruit salad* — Children enjoy cutting up all kinds of fruit and mixing them together. This activity helps your class learn the names of different goods as well as how to cut various fruits.
9. *Butter* — Heavy cream in a jar with lid and shake.
10. *Whipped cream* — Just shake heavy cream in a jar or use an egg beater with some heavy cream and add a little sugar, maybe some vanilla and you have a great topping for cakes, jello, practically anything. Shaking involves grasping, wrist and/or arm movements. Egg beaters also require wrist movements and grasping.
11. *Applesauce* — Peel and core apples, cut them up and cover them with water. Your class will enjoy cutting the apples, stirring the sauce and eating the end result of their work. Through this activity they will also improve their manual skills.
12. *Tuna fish salad* — An easy, fast cold dish. It involves cutting up vegetables (i.e., celery), measuring and mixing.
13. *Hard-boiled eggs* — Easy to make. Children enjoy learning the difference between liquid and solid eggs. Peeling these eggs also helps enhance the child's manual coordination.
14. *Vegetable soup* — Beef or chicken broth with cut-up vegetables; children learn the names of vegetables that they eat. It's fun to introduce new foods through class cooking projects.
15. *Scrambled eggs* — Children like cracking the eggs, pouring, stirring and eating them.
16. *Complex cooking activities* — The following are a little more complex than the others. Because of this, these activities require the teacher to take a more active role and provide more equipment. These recipes involve measuring, pouring, mixing, kneading (bread), cookie cutters (Christmas cookies), and decorating.
    Birthday cakes
    Jimmies (sprinkles, shots) — for decorating cakes and cookies
    Cookie dough
    Bread dough
    Christmas cookies
    French toast
    Pancakes

VII. Beautiful Junk — Most of these items can be found around the house and are useful in your Head Start classroom for collage, storing equipment, and adding to the housekeeping corner. Circulating a list helps parents take a more active part in Head Start and increases your classroom supplies.

empty boxes — shoe boxes any type
paper towel or tissue
old ribbons
cookie-box paper and trays
egg boxes
plastic spools from cameras
containers that slide and move
wrapping paper
cereal boxes
milk or juice containers
cloth
soup cans and other cans
nails and wood scraps
bottle tops
plastic bottles
sponges
hair rollers
baby food jars and tops
cotton
plastic or paper straws
popsicle sticks

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plastic containers
thread spools
old socks
paper bags
dried beans or peas
food coloring
aluminum foil
cardboard
magazines
newspaper
cigarette packages
margarine containers
wallpaper scraps
buttons
string
toothpicks
fruit or meat trays
clothes hangers
corks
old sheets, table cloths
artificial flowers
old clothes
pine cones
birch bark
clothes pins
old telephones
egg beaters
beads, sequins
shells, pebbles
broken crayons
wheels
keys
plastic spoons and forks
sandpaper
wallpaper paste
tonic, beer crates
carpet scraps
funnels, measuring cups
squeeze or squirt bottles
pill containers
floor tiles
pieces of screen
tongue depressors
yarn
candles
zippers
sand
pieces of rope
picture frames
old pocket balls
old clocks
old jewelry
seeds
burlap
shoelaces

VIII. Children's Books The following books, designed to be read to preschool children, deal with differences between children, problems which occur during the course of normal development, birth of a new sibling, hospital visits. These are an enjoyable and subtle way to open discussions about particular problems that arise during the Head Start year.

A. *Books that deal with normal problems and stumbling blocks of development*

Berger, Terry. *I Have Feelings.* New York: Behavioral Publications, 1974.

Seventeen different feelings, each depicted by a specific situation, are explained by the author.

Fischer, Hans. *Pitschi.* New York: Harcourt, Brace and World, Inc., 1953.

Pitschi, a curious kitten who longs to be something else besides a kitten, learns that he does enjoy being a kitten after all.

Switzer, Dr. Robert, Dr. J. Cotter Hirschberg, and Jane Werner Watson. *The Golden Press Read Together Books for Parents and Children.* New York: Golden Press.

1. *My Friend the Doctor*
2. *My Friend the Dentist*
3. *My Body — How It Works*
4. *My Friend the Babysitter*
5. *Look At Me Now*
6. *Sometimes I'm Jealous*
7. *Sometimes I'm Afraid*
8. *Sometimes I'm Angry*

These books are designed to help parents and preschool children understand and overcome normal developmental problems and emotions encountered by most children. The series, although intended for parents and children, can be quite useful for classroom reading and discussion as well.

B. *Books about differences between children*

Beim, Jerold. *The Smallest Boy in the Class.* William Morrow & Co., 1951.

The smallest boy in the class learns that other things beside size are important.

Ericeson, Mary K. *About Glasses for Gladys.* Melmont, 1962.

Children make fun of the way Gladys reads and writes until one day she gets glasses.

Ginsburg, Mirra (illustrated by Jose and Ariane Aruego). *The Chick and the Duckling.* New York: The Macmillan Co., 1972.

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Newly hatched, a chick and a duckling explore the world. They soon find out that what one can do is not necessarily what the other can do too.

Green, Mary. *Is It Hard? Is It Easy?* New York: William R. Scott, Inc., 1960.
A boy and girl discover that different things are hard and easy.

Krasilovsky, Phyllis (illustrated by Ninon). *The Very Little Boy.* Doubleday and Co., 1962.
The very little boy finds that although he is little he can be accepted.

Krasilovsky, Phyllis (illustrated by Coe). *The Very Tall Girl.* Garden City, New York: Doubleday and Co., 1969.
The author gives a charming account of a little girl who is taller than her friends.

Kraus, Robert. *Leo the Late Bloomer.* New York: Windmill Books, 1971.
Leo the lion takes longer than his friends to do things until one day he catches up to their faster pace.

Ronnei, Eleanor C. and Joan Porter. *Tim and His Hearing Aid.* Washington: Alexander Graham Bell Association. $1.00
A picture book for children who wear hearing aids.

C. *Books that deal with the birth of a new sibling*

Hoban, Russell. *A Baby Sister for Frances.* New York: Harper & Row, 1964.
Frances, a raccoon, is jealous of the new baby sister but learns to like her.

Langstaff, Nancy. *A Tiny Baby For You.* New York: Harcourt, Brace and World, Inc., 1955.
Real photographs and text show what a new baby is like.

Schick, Eleanor. *Peggy's New Brother.* New York: Macmillan and Co., 1970.
Although Peggy really wanted a dog, not a new brother, she comes to realize that her new brother will be somebody to share things with.

Schlein, Miriam. *Laurie's New Brother.* Abelard, 1961.
Laurie learns to accept a baby as a new member of her family.

D. *Books that help prepare children for hospital visits*

Chase, Francine. *A Visit to the Hospital* (illustrated by James Bama). Prepared under the supervision of Lester L. Coleman, M.D. New York: Grosset and Dunlap, 1971.
Stevie goes to the hospital to have his tonsils out. The book helps prepare children for a hospital visit by acquainting them with what a hospital is like, and the roles of doctors and nurses in their visit.

Shay, Arthur. *What Happens When You Go to the Hospital.* Chicago: Reilly and Lee, 1969.
Karen's progress from the doctor's office to the hospital and home again after her tonsillectomy is described in an interesting narrative and vivid photographs of the whole process.

Rey, M. *Curious George Goes to the Hospital.* Boston: Houghton and Mifflin Co., 1966.
A child's fears about going to the hospital will be relieved as he reads about Curious George, the monkey, and his exploits in the hospital.

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Appendix 2

BIBLIOGRAPHY

In order to guide Head Start staff toward materials that will be useful in supplementing understanding of growth and development of children as well as particular special needs, we have compiled the following bibliography. This bibliography has been divided into five sections.

Section I

Child Development: Books and articles in this section deal with physical, emotional and intellectual growth of children. Through these books the reader can develop an understanding of how children in general grow and learn.

Section II

Quick Reference: A collection of books and articles which will help the reader obtain some helpful, easy curriculum ideas and classroom activities; and materials that offer a simple discussion of special needs. This section provides materials that can be used quickly and easily to answer staff's questions.

Section III

Further Information: This section provides more extensive reading in the areas mentioned above. These references are particularly helpful if the reader wants to broaden his/her knowledge in a certain field.

Section IV

Films: These films give a realistic portrayal of children with special needs in their daily home and school life. Rental varies from between $10 and $35 for each film.

Section V

Publishing Houses and Directories of Services: Lists the major publishing houses for most of the materials listed as well as other writings in the areas of child development, education and children with special needs. This section also provides directories of services that have been compiled by specified organizations in the above fields.

I. CHILD DEVELOPMENT

Buxbaum, Edith. *Your Child Makes Sense: A Guidebook for Parents.* New York: International Universities Press, 1949.

This book focuses on the physical, emotional and intellectual development of young children in very practical terms. Questions such as why children suck their thumbs, why they sometimes disobey, bedwetting, sex play and many more are discussed.

Fraiberg, S. *The Magic Years: Understanding and Handling the Problems of Early Childhood.* New York: Charles Scribner's Sons, 1959.

A practical book which discusses developmental problems of children from birth to six years.

Gesell, Arnold, et al. *The First Five Years of Life.* New York: Harper and Row, 1940.

This book is useful as a guide to what children in general are like at different ages. However, it is useful to remember when reading it that there are great differences to be expected among children at all ages, and that all children vary in their rate of growth.

Hartley, Ruth E., Lawrence K. Frank, and Robert M. Golderson. *Understanding Children's Play.* New York: Crowell, Collier and Macmillan, Inc., 1957.

A general guide to understanding the developmental significance of different forms of children's play.

Hymes, James. *The Child Under Six.* Englewood Cliffs, New Jersey: Prentice-Hall, 1963.

A simplified version of the development of the child from birth to six years.

Murphy, Lois, and Ethel Leeper. *Caring for Children Series.* U.S. Department of Health, Education, and Welfare, Office of Child Development, Bureau of Child Development Services. Washington, D.C.: U.S. Government Printing Office.

Number One: The Ways Children Learn — DHEW Publication No. (OCD) 73-1026

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A practical, easy-to-read pamphlet which tells how children learn, what they need to know and how the teacher can help them learn.

Number Two: More Than a Teacher – DHEW Publication No. (OCD) 73-1027

A pamphlet which tells how day care workers contribute to the child's development by giving him or her love and understanding as well as teaching.

Number Three: Preparing for Change – DHEW Publication No. (OCD) 73-1028

Practical advice on how to help a child prepare for new and sometimes disturbing situations in his life.

Number Four: Away From Bedlam – DHEW Publication No. (OCD) 73-1029

Practical advice on finding the causes of and prevention of bedlam in the child care center.

Number Five: The Vulnerable Child – DHEW Publication No. (OCD) 73-1030

This booklet describes some of the physical and emotional handicaps that make a child vulnerable, and talks about everyday fears and stress common to children.

Number Six: A Setting for Growth – DHEW Publication No. (OCD) 74-1031

The booklet tells in detail how to make a child care center into a homelike, cheerful place reflecting warmth and security as a good home does.

Number Seven: The Individual Child – DHEW Publication No. (OCD) 74-1032

Describes the uniqueness of each child making clear that every child is different in appearance, temperament, abilities, and attitudes.

Number Eight: From "I" to "We" – DHEW Publication No. (OCD) 74-1033

A guide for child center personnel to teach the child to grow up physically, mentally and socially and to grow out of his "I" selfish confines of his ego world and become a socially responsive citizen of a "We" world.

Number Nine: Conditions for Learning – DHEW Publication No. (OCD) 74-1034

This booklet looks into ways a child care center can provide the conditions that lead to learning. It emphasizes that a healthy baby wants to learn and will learn if the conditions around him are right for learning.

Number Ten: Language Is For Communication – DHEW Publication No. (OCD) 74-1035

Brings out the importance of a good knowledge of language which opens the door to communication, thus helping the child to grow socially and to increase his friendships.

Salk, Lee. *What Every Child Would Like His Parents to Know.* New York: David McKay, 1972.

Parents and teachers will find this book very helpful for understanding why children behave as they do. Dr. Salk has very sound advice for dealing with both the questions young children ask and so-called "problem" behaviors.

Stone, Joseph and Joseph Church. *Childhood and Adolescence: A Psychology of the Growing Person.* New York: Random House, 1968.

This book is a survey of human growth and development from birth through adolescence. Of particular interest to Head Start staff is the discussion of the preschool (3 to 5 year old) child. Stone and Church also present material on "Disturbances in Development" including a section on toddlerhood and the preschool years. The authors make their material extremely readable while presenting core facts about development.

Spock, Benjamin, M.D. *Baby and Child Care.* New York: Pocket Books, Simon and Schuster, April 1973.

Dr. Spock's classic book addresses parents' questions about their children. Of particular interest to the preschool teacher and parent is the section on children aged three to six. For the integration of children with special needs into Head Start, Dr. Spock has a section on Special Problems including a chapter on the handicapped child.

Woodward, O. M. *The Earliest Years: Growth and*

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Development of Children Under Five. New York: Pergamon Press, 1966.

Deals with patterns of normal development during the first five years of life with special consideration given to habit-training in areas such as feeding and toilet-training. The values of play and suitability of play materials are also covered.

II. QUICK REFERENCES

Children With Special Needs

The Exceptional Parent Magazine: Practical Guidance for the Parents of Exceptional Children. Boston: Psy-Ed Corporation.

A new magazine that will be of interest to anyone concerned with special children. It deals with special problems from the parents' point of view, provides technical information stripped of professional jargon and practical advice on day-to-day care. Published 6 times a year; subscriptions are $2.00 a copy, $12.00 a year. Write the Psy-Ed Corporation, 264 Beacon Street, Boston, Massachusetts 02116.

Granato, Sam and Elizabeth Krone. *Day Care 8: Serving Children with Special Needs.* U.S. Department of Health, Education and Welfare, Office of Child Development, 1972.

An excellent discussion of staff, parents, curricula, and materials needed in day care programs for children with special needs.

Klein, Dr. Jenny. "When Handicapped Children Join Regular Classrooms." ERIC/ECE Newsletter, Vol. 7, No. 1, June, 1973.

Dr. Klein provides helpful ideas to teachers who are integrating handicapped children into their classes. The article focuses on teachers, parents and children involved in this process.

Spock, Benjamin and Marion Lerrigo. *Caring for Your Disabled Child.* New York: The Macmillan Co., 1965.
(Also in paperback, Collier-Macmillan Publishers)

A reference book for parents on caring for their disabled children: suggestions about medical care, education, home management.

Curriculum Ideas, Classroom Activities

Braley, William T., M. Ed., Geraldine Komick, and Catherine Leedy. *Daily Sensorimotor Training Activities: A Handbook for Teachers and Parents of Preschool Children.* Educational Activities, Inc., Freeport, Long Island, New York, 1968.

This daily activity guide gives the teacher a comprehensive curriculum aimed at improving the child's sensorimotor skills. This manual is great for all children, but especially for the child who has not yet been able to effectively integrate his sensorimotor skills.

Brown, Carolyn. *For Beginning-to-be Teachers of Beginning-to-be Students.* Nashville, Tennessee: Demonstration and Research College for Early Education, George Peabody College for Teachers, 1971. $1.50

A simple and practical guide for teachers just starting to teach preschool children. It includes materials about child development, curriculum and working with parents.

Engel, Rose C., William R. Ried, and Donald P. Rucker. *Language Development Experiences for Young Children.* Department of Exceptional Children, School of Education, University of Southern California, 1966.

This book provides help to the teacher in a twofold manner:

1) it explains what the pattern of normal language development is,
2) it provides many classroom experiences that foster language learning.

Kircher, Clara J. *Behavior Patterns in Children's Books: A Bibliography.* Washington, D.C.: The Catholic University of America Press, 1966.

Children's books are divided according to various areas of special concern (e.g., physical handicaps, differences between children). These children's books are useful in opening discussions in these various areas.

School Before Six A Diagnostic Approach. Department of Human Development and Family Studies, Cornell University, Ithaca, New York 14850. $5.00

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A complete preschool curriculum. Pages and pages of good ideas.

Teaching Exceptional Children. The Council for Exceptional Children, 1920 Association Drive, Reston, Virginia, 22091. $7.50/year, 4 issues.

This magazine provides many creative curriculum ideas for children with special needs from preschool through adolescence.

Tucker, Dorothy, Barbara-Jeanne Seabury, and Norma Canner. *Foundations for Learning with Creative Art and Creative Movement.* Massachusetts Divison of Mental Health, Department of Mental Health, 1967.

This book, originally developed for Massachusetts Head Start, is an excellent source of ideas for creative art and movement in the preschool classroom. The authors focus on various areas of development: language and communication skills; large and small motor development; sensory image; body image. The book also provides curriculum ideas for activities in each of these areas.

Warner, Dianne and Jeanne Quill. *Beautiful Junk.* DHEW Publication No. (OCD) 73-1036)). U.S. Department of Health, Education, and Welfare, Office of Child Development, Project Head Start. Washington, D.C.: U.S. Government Printing Office.

A list of sources of free or inexpensive materials for early childhood programs and suggestions about how to use them.

Blind and Visually-Impaired Children

Krebs, Mrs. Gordon. *The Blind Child in Kindergarten.* New York: Commission for the Blind, New York State Department of Social Welfare, 270 Broadway; Booklet No. 202.

A kindergarten teacher tells of her experience with two blind children in her regular classroom. Discusses cooperation, acceptance by other children, adaptations of the program.

Moor, Pauline M. *A Blind Child, Too, Can Go to Nursery School.* New York: American Foundation for the Blind, Preschool Series No. 1, 1962. 25¢

An excellent pamphlet describing the integration of blind children into regular nursery school programs. It discusses the questions raised by nursery school teachers about enrolling blind children; how to introduce the child to the school; what to expect of a blind child in terms of participation in activities and performance; how to prepare the other children for a blind child in the class.

Moor, Pauline M. "Toilet Habits: Suggestions for Training a Blind Child." American Foundation for the Blind, 15 West Street, New York, New York.

This pamphlet offers a concrete program for toilet training the young blind child.

Moor, Pauline M. "What Teachers are Saying — About the Young Blind Child." *The Journal of Nursery Education.* Vol. XV, No. 2, Winter, 1960.

Ms. Moor discusses various aspects of the preschool experience for the blind child in a class with sighted children. Concerns and needs of teachers and parents are all considered in paving the way for a blind child to enter a regular preschool.

Pfeiffer, Elsbeth. *Study of Joe — A Blind Child in a Sighted Group.* New York: Bank Street College of Education, 69 Bank Street 10014, 1958.

An excellent pamphlet written by a teacher about Joe, a blind child who entered her regular nursery school program. Describes in detail the daily activities Joe could join in and how staff were able to adapt their program to meet his needs.

Children With Cerebral Palsy

Finnie, Nancie. *Handling the Young Cerebral Palsied Child at Home.* New York: E. P. Dutton and Co., 1968.

An excellent guide for parents, nurses, therapists and others involved in caring for young cerebral palsied children. Hints on carrying, bathing, toilet training, dressing, feeding, playing. Contains a list of addresses of suppliers of accessories and equipment, chairs, feeding and drinking utensils, strollers, toys, etc.

Children With Cystic Fibrosis

National Cystic Fibrosis Research Foundation, "A C/F Child Is In Your Class: A Teacher's Guide to Cystic

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Fibrosis." 3379 Peachtree Road, N.E., Atlanta, Georgia 30326.
Pamphlet available from above address or your local chapter.

Especially geared for teachers, this pamphlet explains what cystic fibrosis is and how you can accommodate the child who has CF in your classroom.

National Cystic Fibrosis Research Foundation. "Your Child and Cystic Fibrosis." (see address above)

This pamphlet explains to parents who have a child with cystic fibrosis the origins of the problems and what parents and doctors can do for this child. This explanation of cystic fibrosis would also be very helpful to a teacher who has a child with cystic fibrosis in her class.

Children With Epilepsy

Barrows, Dr. Howard S. and Dr. Eli S. Goldensohn. "Handbook for Parents." Ayerst Laboratories, Inc. Distributed for no charge compliments of your local Epilepsy Association chapter.

This pamphlet explains in a straightforward manner what epilepsy is, how it is treated, and how it affects the child who has it. It is a good first exposure to understand epilepsy.

Children With Hearing and Speech Problems

Adler, Irving and Ruth. *Your Ears*. New York: The John Day Company. $2.68.

Easy-to-read information on the ear and hearing.

If You Have A Deaf Child: A Collection of Helpful Hints to Mothers of Deaf Children. Urbana, Illinois: University of Illinois Press. $1.00.

Myklebust, Helmer R. *Your Deaf Child: A Guide for Parents*. Springfield, Illinois: Charles C Thomas Co., 1950. $4.79.

This book describes the kinds of problems confronting parents in caring for the deaf child and ways to meet the child's needs.

Palmer, Charles C. *Speech and Hearing Problems: A Guide for Teachers and Parents*. Springfield, Illinois: Charles C Thomas Co., 1961.

An excellent book in question and answer format divided into two parts: the first deals with speech problems, the second with hearing problems. Suggestions of what to do and where to go for help.

Project Head Start Rainbow Series. *Speech, Language, and Hearing Program*. Booklet No. 13. DHEW Publication No. (OCD) 73-1025. U.S. Department of Health, Education, and Welfare, Office of Child Development, Washington, D.C.: U.S. Government Printing Office.

This pamphlet provides a good readable explanation of the Head Start language program, normal language development and developmental problems.

Taylor, Martha L. *Understanding Aphasia*. Patient Publication No. 2, The Institute of Physical Medicine and Rehabilitation, New York University, Bellevue Medical Center, New York, 1958.

Practical suggestions are provided for understanding and working with the aphasic child and his family.

Mentally Retarded Children

Bensberg, Gerald. *Teaching the Mentally Retarded – A Handbook for Ward Personnel*. Atlanta, Georgia: Southern Regional Education Board, 130 Sixth Street, N.W. 30313 $3.00.

An excellent manual for parent and teachers as well as ward personnel. It presents principles and methods for teaching the mentally retarded the various skills and information required for them to be as independent as possible – language development, self-care, etc.

Klebanoff, Harriet, Dr. Lewis B. Klebanoff and Dorothy G. Tucker. *Home Stimulation for the Young Developmentally Disabled Child*. Media Resource Center, 633 Trapelo Road, Waltham, Massachusetts, 1973.

This manual is currently being reprinted and should be available in the immediate future at a price not yet specified. Although this book is designed for parents of very young mentally retarded children, Head Start staff will find that the information can be extended into dealing with these children at the Head Start level. The narrative combined with many photographs of children and parents presents the material in an interesting and readable format.

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Levinson, Abraham, M.D. *The Mentally Retarded Child*. John Day Co., New York, 1965.

Dr. Levinson discussed various aspects of mental retardation including parental reactions to a child's retardation as well as educational implications for the child. A helpful question and answer section speaks to many common questions about the retarded child.

Children With Learning Disabilities

Flowers, Ann M. *Helping the Child With a Learning Disability: Suggestions for Parents*. Danville, Illinois: Interstate Printers and Publishers, Inc., 1969.

Written for parents of children with learning disabilities, this booklet provides information on the nature of learning and suggests activities parents may use to help children become more aware of their environment and to stimulate their learning.

Golick, Margaret. *A Parent's Guide to Learning Problems*. Montreal, Quebec: Quebec Association for Children With Learning Disabilities, 1970.

Useful to both parents and teachers, this guide discusses how to help the child with learning problems assume responsibility. The learning process is described and learning activities are suggested which can be carried out in the kitchen and elsewhere in the home.

Guide for Parents of Learning Disabled Children. San Rafael, California, 1969.

Written for parents of children with learning disabilities, this text offers practical hints for the solution of various educational, physical and social problems.

Hart, Hane, and Beverly Jones. *Where's Hannah? A Handbook for Parents and Teachers of Children with Learning Disorders*. New York: Hart Publishing Company, 1968.

Hannah's parents help her learn through breaking down and simplifying tasks.

Children With Social and Emotional Problems

Moule, K. *A Parent's Guide to Hyperactivity in Children*. Montreal, Quebec: Quebec Association for Children With Learning Disabilities, 1971.

Discusses the causes and effects of hyperactivity in children, how parents can help the hyperactive child, different methods of management and possible problems arising during a day with a hyperactive child.

III. FURTHER INFORMATION

Children With Special Needs

Calovini, Gloria. *The Principal Looks at Classes for the Physically Handicapped*. Washington, D.C.: The Council for Exceptional Children, NEA, 1201 Sixteenth Street, N.W., 1969. $1.75.

Feeding the Child With a Handicap. Public Health Service, Health Services Administration, Bureau of Community Health Services. Washington, D.C.: U.S. Government Printing Office.

This pamphlet provides many helpful suggestions to the parents of a handicapped child who has bleeding problems.

Kough, Jack and Robert De Haan. *Identifying Children With Special Needs*. Science Research Associates, Inc.

A book to help identify children in the classroom with potential special needs. Lists observable characteristics of children with hearing and visual problems, physical disabilities, speech problems, learning and emotional problems.

Richmond, Julius B., M.D. "The Family and the Handicapped Child." *Clinical Proceedings*, Children's Hospital National Medical Center, Vol. XXIX, No. 7, July, 1973, pp. 156-164.

The psychological adaptive processes that a family undergoes upon learning of their child's handicap are described by Dr. Richmond.

The Volta Review. Washington, D.C.: Editorial Office, 1537 35th Street, N.W.

A monthly magazine which contains articles for both professional workers and parents. Membership fee is $3.00.

Curriculum Ideas, Classroom Activities

Behrmann, Polly and Jean Millman. *Excel: Experience*

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for Children in Learning. Cambridge: Mass. Educators Publishing Service, Inc., 1968.

A good collection of simple activities to promote oral expression, visual discrimination, auditory discrimination, and motor coordination in preschool children. It emphasizes family-oriented activities, but is also useful in the classroom.

Doward, Barbara. *Teaching Aids and Toys for Handicapped Children*. Washington, D.C.: The Council for Exceptional Children, 1960. $1.75.

Describes how to make and use a number of teaching aids and toys for cerebral palsied children of nursery school and kindergarten age. The toys have also been used with brain-injured, mentally retarded and multiple-handicapped children.

Franzen, Jane. *Toys, the Tools of Children*. Chicago: National Society for Crippled Children and Adults, 2023 Ogden Avenue 60612, 1957. $5.00.

Analysis of toys and their use with normal children and in the training and treatment of the physically disabled. Useful as a selection guide for parents, teachers, therapists, physicians and others concerned with children's growth and development.

Gordon, Ronnie. *The Design of a Preschool "Learning Laboratory" in a Rehabilitation Center*. Rehabilitation Monograph No. 39. New York: Institute of Rehabilitation Medicine, New York University Medical Center, 1969.

Focusing on the "Learning Laboratory" at the Institute of Rehabilitation Medicine, this booklet provides helpful suggestions for integrating physically handicapped children into preschool classrooms.

Gordon, Ronnie. *The Design of a Preschool Therapeutic Playground: An Outdoor "Learning Laboratory."* Rehabilitation Monograph No. 47. New York: Institute of Rehabilitation Medicine, New York University Medical Center, 1972.

This booklet offers practical suggestions for playgrounds for the physically handicapped preschool child.

Karnes, Merle B. *Helping Young Children Develop Language Skills: A Book of Activities*. Arlington, Virginia: The Council for Exceptional Children, 1968. $3.50.

A book of activities for teachers to help all preschool children develop skills related to all aspects of language development.

Valette, R. I. *Modifying Children's Behavior: A Guide for Parents and Professionals*. Palo Alto, California: Fearon Publishers, 1969.

Presents information for parents on behavior and behavior modification for use in self-instruction, parent counseling, parent education or teacher inservice training.

Weikart, Rogers and Adcock. *The Cognitively Oriented Curriculum: A Framework for Preschool Teachers*. Publications Department, National Association for the Education of Young Children, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009. $3.50.

A useful approach to learning in the preschool.

Blind and Visually-Impaired Children

Burlingham, Dorothy. *Psychoanalytic Studies of the Sighted and the Blind*. International University Press, 1972.

Divided into two sections, one dealing with sighted children, the other dealing with blind children, the author offers a comparison of their development. From both an educational and psychoanalytic viewpoint the author discusses special problems the blind child encounters in routines and experiences that have been designed for the sighted child.

Fraiberg, Selma, Marguerite Smith, and Edna Adelson. "An Education Program for Blind Infants." *The Journal of Special Education*, Vol. 3, No. 2, Summer, 1969.

This program focuses on the establishment of a love bond between the non-sighted child and his parents as the basis of the child's developmental success.

Halliday, Carol. *The Visually Impaired Child: Growth, Learning, Development, Infancy to School Age*. Louisville, Kentucky: American Printing House for the Blind, 1971. $3.25.

An excellent practical manual for parents and teachers on the care, training and instruction of the

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visually impaired child from birth until entry into a formal school program. It describes the basic needs a visually impaired child shares with all children and presents in outline form how all children normally develop. It lists and describes educational materials and practical techniques to help the visually impaired child at each stage of development.

Pelone, Anthony. *Helping the Visually Handicapped Child in a Regular Class*. New York: Teachers College Press, Teachers College, Columbia University, 1957. $2.25.

Describes the needs of children with visual problems in regular classrooms, the roles of various school personnel (nurse, teacher, counselor, psychologist) in meeting these needs, curriculum adaptations for the regular classroom setting. It deals with school age children only.

South, Margarette A., Morton Chetnik, and Edna Adelson. "Differential Assessment of 'Blindisms'." *American Journal of Orthopsychiatry*. October, 1969, Vol. 39, No. 5, pp. 807-815.

'Blindisms', repetitive behaviors which range from simple to complete ritualistic actions are often exhibited by blind people. This longitudinal study discusses some reasons for the formation of these behavior patterns through documented case histories.

Toys For Early Development of the Young Blind Child: A Guide for Parents. Springfield, Illinois: The Office of the Superintendent of Public Instruction, 1971.

A list of toys to help the blind child in his early development. Toys are categorized according to purpose and age of the child from infancy to age three.

Children With Cerebral Palsy

Cooper, John M. and Lawrence E. Morehouse. *Assisting the Cerebral Palsied Child - Lifting and Carrying*. Booklet I: In the Home, Booklet II: Outside the Home. United Cerebral Palsy Associations, 321 W. 44 Street, New York, New York, 1959.

These booklets are designed to help parents and school personnel to transport the child with cerebral palsy in the least strenuous ways possible.

Hebel, Elsie, Sherwood Meisner and L. Leon Reid. *Opening New Doors to the Cerebral Palsied Through Day Care and Development Centers*. New York: United Cerebral Palsy Association, Inc.

A booklet discussing the administration, programs, staff and parent services in day care programs for cerebral palsied children.

Please Help Us Help Ourselves. United Cerebral Palsy Association of Central Indiana, Inc., 615 Alabama Street, Indianapolis, Indiana, 46204. $2.00.

This manual contains directions for constructing easily made, inexpensive adaptive equipment for the physically disabled child: cardboard tables and chairs, styrofoam sit-up table boxes, handles for utensils and games, bicycle pedals, etc.

Children With Hearing and Speech Problems

Greenberg, Joanne. *In This Sign*. New York: Holt, Rinehart and Winston, 1970.

This is a novel providing an extremely sensitive and informative picture of the difficulties of deaf people in learning to communicate, and the different ways these difficulties are overcome.

Harris, Grace M. *For Parents of Very Young Deaf Children*. Washington, D.C.: Alexander Graham Bell Association for the Deaf. 60¢.

Lassman, Grace Harris. *Language for the Preschool Deaf Child*. New York: Grune and Stratton, Inc., 1950. $7.45.

A teacher of the deaf discusses fundamental concepts, activities and training techniques, also includes a design for nursery school and parent education and selected case histories.

Learning to Talk. Information Office, National Institute of Neurological Diseases and Stroke, National Institute of Health, Bethesda, Maryland, 20014, 1969. 45¢.

This pamphlet discusses speech, hearing and language problems in the preschool child. It also describes normal language development in children from 3 months to 5 years.

Lowell, Edgar L. and Marguerite Stoner. *Play It By Ear*. Los Angeles: Educational Materials Depart-

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ment, John Tracy Clinic, 806 West Adams Boulevard 90007. $3.50

Auditory training games for young deaf and hard-of-hearing children.

Newton, Mary Griffith. *Books for Deaf Children*. Washington, D.C.: Alexander Graham Bell Association.

Suggestions of books for nursery school through grade 9.

Utley, Jean. *What's Its Name? A Guide to Speech and Hearing Development*. Urbana, Illinois: University of Illinois Press, 1968.

A workbook designed for parents and teachers of hearing impaired children.

Mentally Retarded Children

Carlson, Laura I. *Play Activities for the Retarded Child*. New York: Abington Press, 1961. $4.00

Ideas for parents and teachers to help the mentally retarded grow and learn though music, games, handicrafts and other play activities.

Dittmann, Laura L. *The Mentally Retarded Child at Home: A Manual for Parents*. Children's Bureau Publication No. 374, U.S. Department of Health, Education, and Welfare. Washington, D.C.: U.S. Government Printing Office, 1959.

This parent manual has many suggestions day care staff will also find helpful. It discusses toilet training, dressing, cleanliness, speech, play, etc., from infancy to adolescence.

Gingland, D. R. and I. Winifred. *Music Activities for Retarded Children: A Handbook for Teachers and Parents*. Nashville, Tennessee: Abington Press, 1965. $3.50

Neglected and Abused Children

Kempe, C. H., M.D., and R. E. Helfer, M.D. (eds.) *Helping the Battered Child and His Family*. Philadelphia: Lippincott, 1972.

Provides a practical approach to dealing with the battered child and his family. The approach is an interdisciplinary compilation of what can be done for battered children and their parents.

Rosenberg, Arthur Harris. *Legal Issues in Child Protective Work*. Boston: Children's Advocates, Inc., 1973.

IV. FILMS

The Aggressive Child. McGraw Films, 1221 Avenue of the Americas, New York, New York 10020. Black and white.

An aggressive child is shown in the various settings which are influencing the child's development: the nursery school, play therapy and home.

Care of the Young Retarded Child. International Film Bureau, 332 South Michigan Avenue, Chicago, Illinois 60603. Color.

This film, geared especially for parents, but useful to teachers, deals with care of a retarded infant. The development of this infant is compared with the development of a normal child. Suggested in the film are ways to care for retarded children.

Janet Is a Little Girl. Extension Media Center, University of California, Berkeley, California. Black and white.

Janet, a Down's Syndrome child who has been placed in an institution, is taught elementary language and reading skills. Although the age range, kindergarten through second grade, is slightly older than the Head Start range, this film will help staff gain a better understanding of retarded children.

Nursery for Blind Children. New York University Film Library, 26 Washington Place, New York, New York 10003. Black and white.

This movie, filmed in England, stresses the importance of teaching blind children not to be afraid. The children engage in physical activities, such as climbing, and enjoy them as other preschool aged children do.

Special Me. Council of Voluntary Organizations for the Handicapped, 615 North Alabama, Indianapolis, Indiana.

Retarded children, partially sighted-blind children, physically handicapped and deaf children are shown in this film. Their developmental successes and

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failures are portrayed realistically. The film gives viewers a good understanding of what working with children with these special needs can be like.

Time for Georgia. Associated Film Consultants, 501 Madison Avenue, New York, New York 10022. Black and white.

Georgia, an autistic child, is shown in a nursery school for emotionally disturbed children.

Where Do the Children Play. Jameson Films, Dallas, Texas. Color.

Community-based day care for profoundly retarded preschoolers stresses that these children can grow and develop outside of institutional settings.

V. PUBLISHING HOUSES AND DIRECTORIES OF SERVICES

American Association of Psychiatric Services for Children, *1973 Directory of Member Services*, 1701 18th Street, N.W., Washington, D.C. 20009

A directory of member services of the AAPSC that can be used to find a resource or treatment service at the local level.

Association for Childhood Education International, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016

Publishes material related to theory, curriculum and methods in early childhood education. Write for a listing.

Bank Street College of Education Publications, 69 Bank Street, New York, New York.

Publishes material related to most aspects of early childhood education. Write for a listing.

CEC Information Center on Exceptional Childre , *A Selected Guide to Public Agencies Concerned with Exceptional Children*, Special Education IMC/RMC Network, 1411 South Jefferson Davis Highway, Suite 928, Arlington, Virginia 22202. May, 1972.

An annotated listing of agencies that serve exceptional children and their families.

Directory of Services for the Deaf in the United States. American Annals of the Deaf, Gallaudet College, Washington, D.C. 20016

A comprehensive listing of schools, clinics, instructional materials, conferences, agencies and organizations for the deaf.

Education Development Center, 55 Chapel Street, Newton, Massachusetts.

Publications on making equipment from free or inexpensive materials and on curriculum. Write for listing.

National Association for the Education of Young Children, Publications Office, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009

This organization publishes books and local newsletters dealing with normal and special child development.

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Appendix 3

READER EVALUATION FORM

We hope that the information and suggestions provided in this manual will help you to meet the needs of handicapped children in your classroom. To increase the usefulness of this manual, a revision already has been undertaken and a new edition will be issued in a few months. The modifications in the new edition will reflect actual Head Start classroom experience with the present manual and will incorporate suggestions from Head Start teachers and consultants associated with Head Start programs.

In order to revise the existing manual to increase its usefulness to you and provide answers to questions that have arisen in your own classrooms, we need information as to where this first edition has served or failed to serve your needs.

We would like to know, for instance, how often you referred to the manual, and on what occasions. Did you find it helpful when you referred to it? If so, in what ways was it helpful? Was there anything about the manual that was unhelpful? If so, what? Where did it fail? Is there information that you looked for in the manual but were unable to find?

We have prepared the following evaluation form, which we hope will help you to formulate and record your reactions to the manual. Please fill it out within two months of receiving the manual. Space is provided at the end of the form for you to record any reactions, comments or suggestions that the preceding list of questions may not have covered.

After filling it out, please return to:

Head Start Project
Judge Baker Guidance Center
295 Longwood Avenue
Boston, Massachusetts 02115

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Reader Evaluation Form

Date the manual was received

Date this form is filled out

1. Location of your program

(city & state)

2. Your staff position

How many other staff members are in your room?

Teachers Aides Volunteers

3. How many social service workers are available for your classroom?

Do you have any consultants? ☐ yes ☐ no

If yes, what kind and for how long?

4. Number of children in your class

5. Number of classrooms in your center

6. What kind of handicaps have you encountered in your class? Please list the handicaps and give some idea of their severity

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7. Have you used any materials besides this manual in order to teach the handicapped children in your class?

☐ yes ☐ no

If yes, what were these materials?

Were they helpful? ☐ yes ☐ no

8. Was this manual interesting and easy to read? ☐ yes ☐ no

Can you tell us why?

9. Did you ever find the manual helpful? ☐ yes ☐ no

Can you tell us when and how?

10. Is there any material you feel is missing from this manual? ☐ yes ☐ no

If yes, what type of material?

11. Is there any material in this manual that you feel should not have been included? ☐ yes ☐ no

If yes, what and why?

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12. About how many times, and on what occasions, have you referred to this manual?

13. Could desired information be found quickly? ☐ yes ☐ no

If no, why not?

14. Can you suggest any changes in the organization of the manual that would make it more useful?

15. Any other comments?

Thank you for your time and help. Your answers will help us to provide you with a better manual.

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